PRINTED: 05/19/2011 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC					OM	IB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPI	LETED
		155777	B. WIN			04/15/2	2011
NAME OF S	DD OLUBED OD GUDDU IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF	PROVIDER OR SUPPLIER	· ·		1750 S	CREASY LANE		
CREASY	SPRINGS HEALTI	H CAMPUS		LAFAYE	ETTE, IN47905		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was	for a Recertification	F0	000	Creasy Springs Health		
	and State Lice	ensure Survey			Campus1750 S. Creasy		
	and State Lie	chisure Burvey.			LaneLafayette, IN 47905Su Event ID: R2L311The	rvey	
					submission of this POC doe	s not	
	Survey dates:	April 11, 12, 13, 14,			indicate an admission by Cr	easy	
	and 15, 2011				Springs Health Campus that		
					findings and allegations con herein are accurate and true		
	Facility numb	er: 012285			representations of the qualit		
	Provider num				care and services provided t	-	
					residents of Creasy Springs		
	AIM number:	201006770			Health Campus. This facility		
					recognized it's obligation to provide legally and medicall	W	
	Survey Team:				necessary care and services	-	
	Megan Wyant	RN, TC			residents in an economic an		
	Linda Campbo				efficient manner. The facility	•	
	Brenda Nunar				hereby maintains it is in substantial compliance with	tho	
	Bieliua Nullai	I, KIN			requirements of participation		
					comprehensive health care		
	Census bed ty	pe:			facilities (for Title 18/19		
	SNF: 36				programs). To this end, this p		
	Residential: 4	0			of correction shall serve as t credible allegation of compli		
	Total: 76				with all state and federal	u1100	
	1000.70				requirements governing the		
		4			management of this facility. thus submitted as a matter of		
	Census payor	type:			statute only. The provider)I	
	Medicare: 29				respectfully requests a desk		
	Medicaid: 0				review with paper compliance	e to	
	Other: 47				be considered in establishin		
	Total: 76				the provider is in substantial compliance.		
	10.001. / 0				COMPRANCE.		
	Complex 10						
	Sample: 10						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

R2L311

Facility ID:

012285

TITLE

(X6) DATE

l	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	(X2) MULTIPLE CO A. BUILDING B. WING	00	l l	E SURVEY PLETED 2011
	PROVIDER OR SUPPLIER SPRINGS HEALTH		1750 S	ADDRESS, CITY, STATE, ZIP CO CREASY LANE ETTE, IN47905	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	Supplemental Residential Sa	_				
		acies also reflect state cordance with 410				
	Quality review 4/20	/11 by Suzanne Williams, RN				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	A. BUII	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING B. WING (A) 00 (A) 04/15/2011			
	PROVIDER OR SUPPLIER		•	1750 S	DDRESS, CITY, STATE, ZIP CODE CREASY LANE TTE, IN47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E.	(X5) COMPLETION DATE
F0157 SS=D	resident; consult wand if known, notifice representative or a when there is an a resident which respotential for requiring significant change mental, or psychosocial statuconditions or clinical ter treatment significant in the psychosocial statuconditions or clinical ter treatment significant in adverse consequence form of treatment facility as specified. The facility must a resident and, if known there is a change in resident state law or regular paragraph (b)(1) of the facility must resupdate the address	is in either life threatening all complications); a need to inificantly (i.e., a need to sting form of treatment due quences, or to commence a nent); or a decision to ge the resident from the d in §483.12(a). Iso promptly notify the pown, the resident's legal interested family member ange in room or roommate pecified in §483.15(e)(2); or ent rights under Federal or ations as specified in					
	Based on intervie facility failed to notified in a time inability to obtain a laboratory cultu	ew and record review, the ensure the physician was ely manner related to the n a sputum specimen for are for 1 of 1 resident elture order in a sample of 7).	F0	157	#27 was admitted to the facil 3-30-11 and admitted to hosp on 4-7-11. The physician and hospice were notified on 4-12 of the staff's inability to obtain sputum culture as noted in th nurses notes on 4-12-11. On 4-13-11 the physician was ag notified of inability to obtain the	ity on Dice I 2-11 In the Ine	05/15/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

R2L311

Facility ID:

012285

If continuation sheet

Page 3 of 86

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155777	B. WIN			04/15/2	011
		1	p. (/1.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	8			CREASY LANE		
CREAS	SPRINGS HEALTH	H CAMPUS		1	ETTE, IN47905		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings include	: :			sputum culture and was ask	ed if	
					he wished a nasal tracheal		
	Resident #27's c	linical record was			sputum obtained, which the physician refused. On 4-13-	11 tho	
		1/11 at 10:10 A.M. The			physician ordered to obtain t		
		nitted with diagnoses			sputum culture if the residen		
		•			produces sputum. The residen		
	1	but were not limited to,			did not have a productive co		
	recent pneumoni				that allowed the sputum to b		
	arteriosclerotic h	neart disease, and left			collected. This hospice resid	ent	
	parietal infarct.				did expire on 4-22-11. IDEN		
					OTHER RESIDENTSIn an a		
	A hospital discha	arge summary dated			of lab forms for all other heal	th	
	1 ^	d "recent methicillin			center residents no other	م سال الله	
					residents had orders for a cuthat had not been able to be	liture	
	resistant staphylo	ococcus aureus			obtained.MEASURES/SYST	EMIC	
	pneumonia."				CHANGESLicensed nursing		
					will be in-serviced on the	otan	
	A physician's ord	der dated 4/6/11 indicated			physician notification policy a	and	
	"sputum culture.	"			procedure.MONITORING		
	1				CORRECTIVE ACTIONThe	DHS	
	A review of labo	oratory reports from 4/6/11			or designee will monitor labs	•	
	1	-			Monday through Friday at th	е	
	"	indicated documentation			Clinical Meeting to ensure		
	~	ted to the sputum culture			physician notification if staff	lah	
	had been done.				unable to obtain the ordered Findings will be reported to a		
					reviewed by the QA Commit		
	Review of lab tra	acking forms dated 4/6/11			monthly for 3 months.	.00	
	1	indicated the sputum			mentally for a mentale.		
	1 -	nable to be collected and					
	1 ~						
		not done. Further review					
		m "MD notified" was					
	blank.						
	Nurses' notes da	ted 4/6/11 through					
	1	d documentation was					
		o the physician being					
	_						
	notified of the in	ability to obtain the					

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155777	B. WIN			04/15/2	011
		1	D. 11111		ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF I	PROVIDER OR SUPPLIEF	₹			CREASY LANE		
CREASY	SPRINGS HEALTH	H CAMPUS		1	ETTE, IN47905		
					,		(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
1110	sputum specimen		-	1710			Ditte
	Sputum specime	ii for culture.					
	Tu4.0 1 4/1	2/11 -4 0-15 A M					
		2/11 at 9:15 A.M. with					
		d she was unaware if the					
	1 ~	nad been done or if the					
	1 ^ -	een notified. She indicated					
	the physician sho	ould have been notified.					
		0/11 - 1 05 D 3 5 - 11					
		3/11 at 1:25 P.M. with					
		nator indicated she was					
		ny documentation related					
	1	being notified of the					
	I -	n the sputum for culture.					
	She indicated he	should have been					
	notified "the nex	t day."					
		4/44 40 . 20 . 1 . 2					
		4/11 at 10:20 A.M. with					
		Health Services indicated					
		d been notified "verbally"					
	but it was not do	ocumented.					
		(11 . 0 10 D) (
		11 at 2:10 P.M. of a					
	1	nd procedure dated					
	12/6/2007 and ti	-					
		delines" indicated					
	"resident asses	sments for change in					
	condition, suspe	cted injury, event of					
	unknown origin	or ordered lab and/or					
	other diagnostic	test should be completed					
	in a timely mann	nerattempts to notify the					
	physician and th	eir response should be					
	documented in the	he resident record"					
	3.1-5(a)(3)						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155777		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/15/2011		
	PROVIDER OR SUPPLIER SPRINGS HEALTH			1750 S	ADDRESS, CITY, STATE, ZIP CODE CREASY LANE ETTE, IN47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
F0176 SS=D	drugs if the interdisby §483.20(d)(2)(ii practice is safe.) Based on obserview and interdisce is safe. Based on obserview and interdisce is safe. Based on obserview and interdisce is safely self-admits for 1 of 1 residents (Residents (Residen	de: cord for Resident #21 on 4/11/11 at 10:05 uded, but were not ile cancer with total pression, congestive ad history of alcohol MENT REVIEW DERATIONS," dated dicated, "Self .No plan of care is	F0	176	CORRECTIVE ACTIONThe medications were removed resident #21's room on 4-11 IDENTIFY OTHER RESIDENTSAll other health center resident's rooms wer audited and no other medications were found at the bedside. MEASURES/SYSTEMIC CHANGESLicensed nursing will be in-serviced regarding importance of observing for medications at the bedside resident. If observed, medicate to be removed and their will evaluate the resident for self-administration of the medications. Additionally an is being prepared for the admission packet for reside and family members educate them that residents may not medications at the bedside without a self-administration assessment being completed. Residents and families will be asked not to bring medication the resident. If the family britany items for resident use, including over-the-counter it they will be asked to take the items to the nurses' station of the for assessment. MONITORI CORRECTIVE ACTIONNurses staff will audit resident room daily to ensure no medication	e ations g staff the any of the ations nurse insert insert have d. oe ons to ngs ems, e first NG sing s	05/15/2011

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUF COMPLET	
AND PLAN	OF CORRECTION	155777		LDING	00	04/15/201	
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				CREASY LANE		
	SPRINGS HEALTH	1 CAMPUS		1	ETTE, IN47905		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E C	OMPLETION DATE
		recapitulation, dated	1	-	are at the bedside without a		
		dicated, "Ventolin			self-administration assessment having been completed. An a	· .	
	·	(every) 4 (symbol			checklist will be provided to t	he	
	, ,	wo) puffs (for)			Director of Health Services of designee daily Monday throu		
	wheezing"	, •			Friday, and will be reported t		
					QA Committee monthly for 3		
	A physician's o	order, dated			months.		
	04/01/2011, in	dicated, "MOM					
	(Milk of Magr	nesia) 60 cc (cubic					
	centimeters) p	o (oral) now & qd					
	(every day) pri	n (as needed) (for)					
	constipation						
	•						
	A MDS assess	ment dated,					
	04/05/2011, in	dicated the resident					
	was cognitivel	y intact.					
	During observ	ations on 04/11/2011					
	at 9:30 a.m. an	nd 10:45 a.m.,					
	Resident # 21	had one bottle of					
	Milk of Magne	esia and one Ventolin					
	inhaler at the b	pedside. The resident					
	indicated he ha	ad used both					
	medications si	nce admission to the					
	facility.						
	During an inte	erview on 04/11/2011					
	at 10:45 a.m.,	RN # 5 indicated					
	medications sh	nould not have been					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ì		ONSTRUCTION 00	(X3) DATE S COMPL	
		155777	A. BUI B. WIN	LDING IG		04/15/20	
NAME OF F	PROVIDER OR SUPPLIER		<i>p.</i> ,,,,,,		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	SPRINGS HEALTH			1	CREASY LANE ETTE, IN47905		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	_	ı	(V5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	'E	DATE
		bedside unless the					
		een assessed for safe					
	self medication	n administration.					
	Duning on into	maiore on 04/11/2011					
	at 10:50 a.m.,	rview on 04/11/2011					
	, ·	10 indicated the					
	resident should						
		ored at the bedside					
		en assessed for safe					
		n administration.					
		i ddiiiiiistidii.					
	An undated po	licy, titled					
	•	OCUMENTATION					
	SYSTEMS Ad	lmission Nursing					
		d Data Collection"					
	was provided l	by the Executive					
	Director on 04	/14/2011 at 1:45 p.m.					
	The policy ind	icated, "The					
	assessment sha	all include					
	identification of	of risk factors					
	through assess	ment, observation					
	and review of	pertinent					
	documentation	that may contribute					
	to additional c	omplications,					
	medical declin	e or safety					
	concerns"						
	3.1-11(a)						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777		A. BUILDING 00 COMPI B. WING 04/15/2		(X3) DATE S COMPL 04/15/2	ETED		
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE CREASY LANE		
CREASY	SPRINGS HEALTH	I CAMPUS			TTE, IN47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0223 SS=D	verbal, sexual, phycorporal punishmens seclusion. The facility must no sexual, or physical punishment, or inverse and punishment	review and interview, the ensure a resident om verbal abuse related to harassment. This e affected 1 of 2 abuse wed, and 1 discharged olemental sample of 1 se. (Resident #38, LPN	F02	223	CORRECTIVE ACTIONAII employees are educated to the facility's policies and procedure garding abuse and neglect resident rights at the time of in New Employee Orientation. The facility policy requires screening of employees, train of employees, prevention steamd identification steps that include prompt reporting of a resident allegations of abuse an allegation is made the firs priority is immediate provisions afety for residents that may include moving the resident than the room, providing one-on-one monitoring if appropriate, or suspending the suspected employee(s) pendoutcome of investigation. An investigation is immediately initiated as well as prompt reporting to the physician, farmember, Triogy management and state agencies. All reside at the time of admission are informed of the facility's zero tolerance for abuse standard how residents may report any concerns they experience where it is the compus. The Executive Director and Directors.	ares and hire n. ning eps II t n of to ne ling mily t ents and y hile	05/15/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			JLTIPLE CON	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION	155777	A. BUIL	DING	00	04/15/2011	
	199777	B. WING			04/15/2011	
NAME OF PROVIDER OR SUPPLIER	₹			DDRESS, CITY, STATE, ZIP CODE		
				CREASY LANE		
CREASY SPRINGS HEALTH	H CAMPUS		LAFAYE	TTE, IN47905		
(X4) ID SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	1
	LSC IDENTIFYING INFORMATION)		TAG		DATE	
	resident's) room (the			Health Services did take	Ale c	
resident) states the	he nurse did not leave at			appropriate action immediate when informed of the resider	•	
first and was arg	umentative Resident			allegations by suspending th		
states she does n	ot want this nurse caring			nurse and CNA working on the		
for her againIn	nmediate action			shift at the time of the incide		
_	nurse and male CNA			and initiating an immediate		
	k a female CNA to			investigation into the residen	I	
` ′	the resident the remainder			allegations. The incident was		
^				reported timely within 24 hou the Indiana State Departmen		
	to alleviate the resident's			Health. IDENTIFY OTHER	it oi	
	aving a male caregiver.			RESIDENTSThe Social Serv	rice	
1	on the resident reporting			Director on 3-6-11 did intervi	l l	
the incident to the	ne Social Services			other alert and oriented resid	lents	
Director (SSD) t	he SSD contacted the			in the health campus and as		
Director of Heal	th Services (DHS) who			they had any concerns with I		
supervises the nu	ursing staff. The DHS			staff had treated them or the care. No other residents	ır	
1 ^	tacted the night nurse			expressed any mistreatment	or	
1	e male CNA (CNA #9)			concern to the Social Service		
` ′	oth placed on suspension			Director. MEASURES/SYST	l l	
1 -	tion of a full investigation			CHANGESEducation for state	f was	
1	Preventative measures			initiated on 3-6-11 for staff from	l l	
				all departments regarding the	I	
	contacted the Executive			facility's policies and procedu		
` ′	apprise her of the			on abuse and neglect and th importance of any staff mem		
	n. The ED contacted the			becoming aware of a resider	I	
resident's POA/s	on to make him aware of			concern to promptly report th	I	
the resident's con	ncerns, the facility's			the Executive Director and/o	l l	
actions taken to	protect the resident and			the Director of Health Service	I	
the on-going inv	estigation into the			appropriate steps can be tak	I	
"	rns. An in-service on the			per facility policy to protect the resident that include suspendent		
	et policies of the campus			the suspected employee(s)	41119	
	all staff on 3-6-11The			pending outcome of		
	Director and ED met with			investigation. All department		
				staffs will be in-serviced on t		
the resident at se	-			abuse and neglect policies a	nd	
afternoon of 3-6-11 and the resident had				procedures including the		
several visitors a	and was smiling an			requirement to promptly repo	יונ	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU COMPLE	
AND PLAN	OF CORRECTION	155777		LDING	00	04/15/20	
		100777	B. WIN		A DDDEGG CITY GTATE ZIR CODE	04/10/20	''
NAME OF	PROVIDER OR SUPPLIEF	2		1	ADDRESS, CITY, STATE, ZIP CODE CREASY LANE		
CREASY	SPRINGS HEALTH	H CAMPUS		1	ETTE, IN47905		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	•	LSC IDENTIFYING INFORMATION)	-	TAG		$\frac{}{}$	DATE
		them and showed no			any allegations.MONITORIN CORRECTIVE ACTIONEach		
	signs of distress.	"			month at Resident Council	·	
		1 / 12 / 1			residents are educated regar		
	1	summary dated March			their rights including the right		
	' '	by the ED was provided			be free from any mistreatment including abuse and neglect		
	1	30 p.m., by the ED and			asked if they have any conce		
		Social Service Director			Any resident allegations of		
		all alert and oriented			suspected abuse will be	.	
		11 on the hallway where			immediately investigated and appropriate and required act		
	,	#6) worked to ensure no			will be implemented including		
		vere concerned with			immediate suspension of the		
		No other residents			suspected employee(s) pend	~ 1	
	1 -	cerns with any staff			outcome of the investigation. investigations are documented.		
		ig multiple investigative			and reported immediately to	-	
		the resident at different			Trilogy division support inclu		
		ifferent individuals this			outcome of the investigation		
		sistent inrecollection of			action steps taken. Additiona all allegations of abuse are	illy,	
	1	appened early in the			reported to the QA committee	e	
	1 -	11. At approximately			monthly and the QA committ	ee	
		ident placedcall light			will review each allegation to		
	1	NA (CNA #9) on duty			ensure the facility policy and procedure was followed.		
		n to assist (the resident).			Should negative trends be no	oted	
	,	ent) realized he was a			the QA committee will report		
	1	t requested that a female			those findings to Trilogy Divis		
		s she was uncomfortable			Support for additional training corrective action.	y and	
		giver. The male CNA			CONTOCUTO GOLION.		
		ent that he understood					
		oom and informed his					
	1	he charge nurse (LPN #6)					
	1	ges that the male CNA					
	1	the resident's request and					
		and the charge nurse					
	1	at the charge nurse entered					
	ine room alone to	o talk with the resident.					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155777	A. BUILDING	00	04/15/2011
		133777	B. WING	PRESIDENCE CONTROL CON	04/13/2011
NAME OF I	PROVIDER OR SUPPLIER		l l	ADDRESS, CITY, STATE, ZIP CODE CREASY LANE	
CREASY	SPRINGS HEALTH	H CAMPUS	l l	ETTE, IN47905	
(X4) ID		TATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
	The resident mai	ntains that the charge			
	nurse began talki	ing to her in an			
	inappropriately lo	oud voice, telling the			
	resident that (the	resident) needed to			
	allow the male C	NA to provide care for			
	(the resident) bed	cause he was scheduled			
	for that hall to ca	re for the resident and			
		ne resident indicates that			
	l '	g the conversation did the			
		irse offer to assist the			
		throom herself The			
		at the charge nurse			
		argumentative with her			
	I -	ver status, allowing the			
		escalate in both tone and			
		ident asked the charge			
		r room and the charge			
		mediately comply with			
	· -	sing an increase in the			
	resident's anxiou				
		rsation the charge nurse			
		m and sought a female			
	~	resident was distressed			
	1	his point. The charge			
		vestigative interview that			
		ake the resident to the			
	· ·	ver the resident remains			
		did not. The charge she did not yell at the			
		resident has remained			
		e nurse did yell at her			
	and was argumer				
	_	erviews were conducted			
	_	mbers working to provide			
	with an stair iller	moors working to provide			

PRINTED: 05/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777		(X2) M A. BUII B. WIN	LDING G	ONSTRUCTION 00	(X3) DATE COMPI 04/15/2	LETED	
NAME OF I	PROVIDER OR SUPPLIE	R		1	ADDRESS, CITY, STATE, ZIP CODE		
CREASY	SPRINGS HEALT	H CAMPUS	1750 S CREASY LANE LAFAYETTE, IN47905				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` `	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)		ATE	COMPLETION DATE
IAG	+	dent on the night shift the		IAU			DATE
		The male and female					
	CNA's that cared for the resident the night of 3-6-11 also noted in investigative						
		he resident expressed					
		about how the charge					
		ner. The charge nurse					
		ge that she did not leave					
		om the first time the					
		During investigative					
		the resident, (the resident)					
		how anxious and fearful					
	· ·	n made her that evening					
		nteraction with the nurse.					
		nained consistent					
		e CNA's, stating they were					
	_	they provided careand					
		ident) was cared for the					
		night. The resident had					
		arding any other staff					
	_	re other than the charge					
		e early morning of 3-6-11.					
	1	sults of the investigation,					
		eceived performance					
		education regarding the					
	_	im communicating					
	_	concerns regarding					
	1	dent's rights or abuse or					
		vas allowed to return to					
	1	all the investigative					
		impus had no alternative					
		the nurse based on her					
	failure to honor	the resident's rights to					
		ment free of harassment					

012285

AND PLAN OF CORRECTION 155777 A BUILDING B WING SURG A BUILDING B WING O0 O4/15/2011 NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG and intimidation that provides the resident choice about treatment and care and dignity" A statement dated March 6, 2011 from CNA #9 indicated "Resident #38 (name) put oncall light, CNA #9 sment to get LPN #6, then CNA #9 went to the bathroom. When CNA #9 sent back LPN #6 had already had some sort of confrontation with her, he had not witnessed. Call light 2nd timeResident #38 (name) grabbed CNA #9\$ shand and kept holding it, and kept apologizing (sic) to him, she kept saying LPN #6 had been so awful to her, and wouldn't leave the room. Resident #38 (name) wouldn't leave the leavecall light 3rd timeasked to use bedpanCNA #9 told her he would get	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
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bedpanCNA #9 told her he would get								
		1						
(female caregiver)Resident #38 (name)		1 *	•					
said no, it was okay for CNA #9 to help		1 `						
herso CNA #9 (name) helped (Resident		· ·	-					
#38) on and off bedpanLPN #6 (name)								
out at nurse's stationmad, and talked to		1	-					
CNA #9 (name)'maybe I was raising my			·					
voice too loud. Kept focusing on it, over		` ′						
and over, said I feel bad, maybe I was too			-					
loud with her'"			-					
Toda with the		iouu witii iici						
		An undated, uns	igned statement from					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777		A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED
	PROVIDER OR SUPPLIER		B. WIN	1750 S	DDRESS, CITY, STATE, ZIP CODE	0 11 10/2	
CREASY	SPRINGS HEALTH	I CAMPUS		LAFAYE	TTE, IN47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	a.m.), Resident p went in- resident did want him to I resident-Told her wanted to tell her was an employee job- and she shou refused to let me her and repriman her and she becan using foul langua hell our of her ro my s**t- Asked I language that it w told me then to g room- that is who summoned (fema take her to BR- 1 call light onsaid CNA #9 (name) her on bed pan Review of LPN # 4/15/11 at 8:45 a had been inservice rights for the 201 The file indicated received any disc related to abuse of 3/10/11. The file ground check had	d"at 0015 am (12:15 ut on call light. Aide wanted to go to BR but help-I went to help I was here to help but that CNA #9 (name) and it was part of his help said I was yelling at ding her I tried to calm me belligerent + was help and it was pert he om that she didn't need her not to use that was not necessary- She het the f**k out of her en I left her room and hour later she put her d she thought maybe would come in and put "" #6's employee file on he, indicated the nurse hed on abuse and resident 0-2011 calendar year. If the LPN had not help in an indicated a back he been completed on the help in the indicated a back he been completed on the help in the indicated a back he been completed on the help in the indicated a back he been completed on the help in the indicated a back he been completed on the help in the indicated a back he been completed on the help in the indicated a back he been completed on the help in the indicated a back he been completed on the help in the indicated a back help in the indicate					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

R2L311

Facility ID:

012285

If continuation sheet

Page 15 of 86

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777		A. BUII	LDING	NSTRUCTION 00		3) DATE SURVEY COMPLETED 04/15/2011	
NAME OF PROVIDER C			B. WIN	1750 S			
(X4) ID S PREFIX (EAC	SUMMARY S H DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
dated 3. violated environ intimidal choice and dignity. provide to meet could have professional atti. The cartinamedi. Review the Executive 11:45 and work in 3-6-11. Resider 4/15/11 indicate facility the residualert and A nurse 3/6/11 and "Resider	I the resident free ation that about treat Addition the resident free ation that about treat Addition the resident ave avoid ave avoid ave avoid ave avoid at a tank tude displays has at a tally term of time secutive Di.m., indice the facility of the resident at #38's reat 10:20 and the resident at 10:20 and the resident at 12:15 and dent put contact and put to the signature of the signature of the signature of the signature of the resident put to the signature of the signature of the resident put to the signature of the signature of the signature of the signature of the resident put to the signature of the signature	inseling record form licated "LPN #6 (name) lent's rights to have an of harassment and provides the resident timent and care and nally she failed to the resident directly and ent's needs when she det the facility's de of conduct or dards in her interaction ayed with the resident. Inot alternative but to minate employment" The punches provided by rector on 4/15/11 at lated LPN #6 did not try after her shift on cord was reviewed on a.m. The record dent was admitted to the The record indicated her own person and was lix 3. Igned by LPN #6, dated, indicated all light on to go to male aide entered she					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777		(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 04/15/20	ETED	
NAME OF	F PROVIDER OR SUPPLIEF		<u> </u>		DDRESS, CITY, STATE, ZIP CODE		
CREAS	Y SPRINGS HEALTI	H CAMPUS			TTE, IN47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	went in room to explain that make Resident became belligerent- usin writer of yelling language c (with and summoned a to assist- When a stated male aid (anytime" A nurses' note da indicated "Wribe tearful this m Services) her too tearfulness" During an interv Services Director 11:20 a.m., she is resident's room to as she was a new indicated it was shared with her to related to LPN # resident reported in her manner of The SSD indicated reported the resident that the ED. She CNA were suspensivestigation. Significant residents of the suspensivestigation.	help her (sic)- writer assist- Attempted to a aide was an employee-every defensive + g foul language- accusing at her + using foul) her- writer left room aid (sic) from another hall aid (sic) helped her she sic) could be in her room teted 3/6/11 at 9:00 a.m., ter observed (resident) to orning. S/S (Social lay et (and) notified of the with the Social of the concern she had the concern she had 6. She indicated the late the nurse had been harsh stalking and was loud. The late the concern to the DHS of the indicated the LPN and anded pending the the indicated the LPN's teraction with the resident					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 04/15/2	LETED	
	PROVIDER OR SUPPLIER		D. WIIV	1750 S	DDRESS, CITY, STATE, ZIP CODE CREASY LANE ETTE, IN47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	was inappropriated During an intervent Director on 4/15 indicated the LP the situation had care. The ED indicated in initially identify as the nurse did to the willful intent She indicated she altercation as neglecture care was aby a female CNA caused the resided did not immediate request for a femindicated the ver willful when the resident's room to request. She indicated the resident of the residence of the r	iew with the Executive /11 at 11:45 a.m., she N could have eliminated she provided the resident dicated she did not the altercation as abusive not enter the room with to abuse the resident. e did not consider the glect as the LPN did provided to the resident A. She indicated the LPN ent anxiety because she tely comply with her hale caregiver. She bal altercation became LPN did not leave the upon the resident's icated the LPN made 2 ments by not providing ent and by not leaving the		TAG	DEFICIENCY)		DATE
	environmentVe	a comfortable and safe erbal abuse-may include estured language that					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777			(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMPI 04/15/2	LETED
	PROVIDER OR SUPPLIER		STREET A 1750 S	ADDRESS, CITY, STATE, ZIP CO CREASY LANE ETTE, IN47905	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	to the resident/pa hearing distance, regardless of the	lisability i. Staff to				

PRINTED: 05/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777			(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/15/2011
		193777	B. WING		04/13/2011
NAME OF F	PROVIDER OR SUPPLIER		l	ADDRESS, CITY, STATE, ZIP CODE CREASY LANE	
CREASY	SPRINGS HEALTH	I CAMPUS	I	ETTE, IN47905	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0225 SS=D	have been found of or mistreating residence had a finding nurse aide registry mistreatment of residence of their property; a has of actions by a employee, which we service as a nurse	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or gentered into the State or concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an awould indicate unfitness for a aide or other facility staff to de registry or licensing			
	authorities.				
	violations involving abuse, including ir and misappropriat reported immediat the facility and to with State law thro	nsure that all alleged g mistreatment, neglect, or njuries of unknown source ion of resident property are rely to the administrator of other officials in accordance ough established procedures tate survey and certification			
	alleged violations	ave evidence that all are thoroughly investigated, further potential abuse while in progress.			
	reported to the add representative and accordance with S State survey and of working days of th	nvestigations must be ministrator or his designated of to other officials in state law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective sen.			
	facility failed to overbal abuse, inti	review and interview, the ensure an incident of imidation and harassment nember and a resident reported and	F0225	CORRECTIVE ACTIONAII employees are educated to t facility's policies and procedu regarding abuse and neglect resident rights at the time of in New Employee Orientation	ures and hire

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155777 04/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1750 S CREASY LANE CREASY SPRINGS HEALTH CAMPUS LAFAYETTE, IN47905 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE investigated. The alleged staff member The facility policy requires screening of employees, training worked the remainder of the shift after the of employees, prevention steps incident occurred. This deficient practice and identification steps that affected 1 of 2 abuse allegations reviewed, include prompt reporting of all resident allegations of abuse. If and 1 discharged resident in a an allegation is made the first supplemental sample of 1 reviewed for priority is immediate provision of abuse. (Resident #38) safety for residents that may include moving the resident to Findings include: another room, providing one-on-one monitoring if appropriate, or suspending the Review of an abuse allegation provided suspected employee(s) pending by the Executive Director on 4/14/11 at outcome of investigation. An 1:10 p.m., indicated the following: investigation is immediately initiated as well as prompt reporting to the physician, family A "fax/incident report" dated March 6, member, Triogy management 2011 indicated "...Brief description of and state agencies. All residents at the time of admission are incident...(Resident #38's name) reported informed of the facility's zero at 10:00 am on 3/6/11 that the night shift tolerance for abuse standard and nurse (LPN #6) last night yelled at her how residents may report any because (the resident) requested a female concerns they experience while staff member to help (the resident) to the residing at the campus. The Executive Director and Director of BR (bathroom) instead of the male staff Health Services did take member that answered her call light. appropriate action immediately When the resident asked the nurse (LPN when informed of the resident's #6) to leave (the resident's) room (the allegations by suspending the nurse and CNA working on the resident) states the nurse did not leave at shift at the time of the incident first and was argumentative... Resident and initiating an immediate states she does not want this nurse caring investigation into the resident's for her again...Immediate action allegations. The incident was reported timely to the Indiana taken...the night nurse and male CNA State Department of Health. The (CNA #9) did ask a female CNA to CNA was counseled and provide care for the resident the remainder in-serviced on 3-7-11 regarding of the night shift to alleviate the resident's resident abuse and fully understands the need to report concern about having a male caregiver.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777		(X2) MU A. BUILI B. WING	DING	OO	(X3) DATE S COMPL 04/15/2	ETED	
	PROVIDER OR SUPPLIER		p. wiito	1750 S C	DDRESS, CITY, STATE, ZIP CODE CREASY LANE TTE, IN47905	l	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Immediately upon the incident to the Director (SSD) to Director of Heal supervises the number immediately conducted (LPN #6) and the and they were been pending completed of the incident The DHS Director (ED) to resident's concernesident's POA/s the resident's concernesident's concernesident at seafternoon of 3-6 several visitors and interacting with signs of distress. An investigation 11, 2011, signed on 4/14/11 at 4:3 indicated "The also interviewed residents on 3-6-	on the resident reporting the Social Services the SSD contacted the th Services (DHS) who the start of the night nurse the male CNA (CNA #9) of the placed on suspension tion of a full investigation the preventative measures contacted the Executive the apprise her of the the non-to-make him aware of the cerns, the facility's the protect the resident and the estigation into the the policies of the campus the all staff on 3-6-11The the Director and ED met with the parate times the the and the resident had the mand showed no			immediately any suspected incidents in the future. IDEN OTHER RESIDENTSThe So Service Director on 3-6-11 d interview all other alert and oriented residents in the heat campus and asked if they hat any concerns with how staff treated them or with their can No other residents expressed mistreatment or concern to the Social Service Director. MEASURES/SYSTEMIC CHANGESEducation for statinitiated on 3-6-11 for staff from all departments regarding the facility's policies and procedure on abuse and neglect and the importance of any staff membecoming aware of a resider concern to promptly report the Executive Director and/of the Director of Health Service appropriate steps can be taken per facility policy to protect the suspected employee(s) pending outcome of investigation. All department staffs will be in-serviced on the abuse and neglect policies as procedures including the requirement to promptly report any allegations. MONITORIN CORRECTIVE ACTIONEach month at Resident Council residents are educated regard their rights including the right be free from any mistreatme including abuse and neglect asked if they have any concern and resident allegations of the suspected allegations of the suspected and they have any concern the suspected and neglect regarded in they have any concern the	cial id Ith id had re. d any he ff was om e cures e ber nt to r es so e e ding he rding t to nt and	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777		A. BUI	LDING	ONSTRUCTION 00		(X3) DATE COMPI 04/15/2	LETED		
		100///		B. WIN				04/13/2	.011
NAME OF I	PROVIDER OR SUPPLIEI	R			1	ADDRESS, CITY, STA	TE, ZIP CODE		
CBEVEA	' SPRINGS HEALTI	H CAMPILS			1	CREASY LANE ETTE, IN47905			
			v aven v ====			_ 1 1 L, 1114 / 905			
(X4) ID PREFIX		STATEMENT OF DEF			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			(X5)
TAG	`	NCY MUST BE PERC R LSC IDENTIFYING			TAG	CROSS-REFERENCE	ED TO THE APPROPRIATICIENCY)	E	COMPLETION DATE
1710	other residents w			+	mo	suspected ab	use will be		DATE
	conduct of staff.						nvestigated and	l all	
	reported any cor						nd required act		
	membersDurir						nented including		
	interviews with						spension of the aployee(s) pend		
	times and with d						ipioyee(s) perion. le investigation.		
							are documente		
	resident was con					and reported	immediately to		
	the events that h						n support inclu		
	morning of 3-6-		•				ie investigation aken. Additiona		
	12:15 am the res	•	•			all allegations		y ,	
	on. The male C	` '	•				e QA committee	Э	
	entered the room	*				monthly and t	he QA committe	ee	
	When (the reside	*					ch allegation to		
	man, the residen	t requested that	t a female				cility policy and is followed. Sho	uld	
	CNA assist her a	ns she was unco	omfortable				ds be noted the		
	with a male care	giver. The ma	le CNA			committee wil			
	assured the resid	lent that he und	lerstood			findings to Tri	logy Division		
	and he left the ro	oom and inform	ned his				dditional training	g or	
	charge nurse. T	he charge nurse	e (LPN #6)			corrective act	ion.		
	both acknowleds	ges that the ma	le CNA						
	informed her of								
	both the resident		-						
	acknowledge that	•							
	the room alone t	_							
	The resident ma								
	nurse began talk		•						
	inappropriately 1	_							
	resident that (the		-						
	allow the male C	· · · · · · · · · · · · · · · · · · ·							
	(the resident) be	-							
	for that hall to ca								
	knew how to. T								
	at not time durin								
	female charge n	-							
FORM CMS-2	2567(02-99) Previous Versi	ons Obsolete	Event ID:	R2L311	Facility 1	^{ID:} 012285	If continuation sl	neet Pa	ge 23 of 86

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPI		
		155777		LDING		04/15/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1	CREASY LANE		
CREASY	SPRINGS HEALTH	I CAMPUS		1	ETTE, IN47905		
(X4) ID		TATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION	
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION) throom herself The	-	TAG	DEFICIENCE		DATE
		at the charge nurse					
	continued to be argumentative with her						
	about the caregiver status, allowing the conversation to escalate in both tone and						
		ident asked the charge					
		r room and the charge					
		nediately comply with					
		sing an increase in the					
	resident's anxious	_					
		rsation the charge nurse					
		m and sought a female					
		resident was distressed					
	l -	nis point. The charge					
	· ·	vestigative interview that					
		ake the resident to the					
		ver the resident remains					
	Í	did not. The charge					
		she did not yell at the					
		esident has remained					
	consistent that th	e nurse did yell at her					
	and was argumen	ntative with her.					
	Investigative inte	erviews were conducted					
	with all staff mer	nbers working to provide					
		ent on the night shift the					
	event occurred.	The male and female					
	CNA's that cared	for the resident the night					
		ted in investigative					
	interviews that th	ne resident expressed					
		about how the charge					
		er. The charge nurse					
		ge that she did not leave					
		m the first time the					
	resident asked. I	During investigative					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE COMPI		
		155777	B. WIN			04/15/2	011
	PROVIDER OR SUPPLIER			1750 S	DDRESS, CITY, STATE, ZIP CODE CREASY LANE		
	SPRINGS HEALTH			LAFAYE	ETTE, IN47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
TAG	interviews with the clearly recalled he this conversation because of the in The resident remainpraise for the wonderful when ensured (the resident remainder of the no concerns regamembers or carnurse on duty the Based on the result the male CNA recounseling and elimportance of him immediately any violation of resident neglect and he work. Based on interview, the carbut to terminate the failure to honor thave an environment and intimidation choice about treadignity" A statement dated CNA #9 indicated put oncall light (The resident) stafemale for her president in the call of	he resident, (the resident) ow anxious and fearful made her that evening teraction with the nurse.		TAG	DEFICIENCY)		DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777		LDING	NSTRUCTION 00	(X3) DATE: COMPL 04/15/2	ETED	
	PROVIDER OR SUPPLIER		1750 S	DDRESS, CITY, STATE, ZIP CODE CREASY LANE ETTE, IN47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	πE	(X5) COMPLETION DATE
	LPN #6 had alreaconfrontation wiwitnessed. Call #38 (name) grabkept holding it, at to him, she kept so awful to her, a room. Resident herself used som because LPN #6 leavecall light bedpanCNA #9 (female caregive said no, it was obherso CNA #9 #38) on and off to out at nurse's star CNA #9 (name). voice too loud. I and over, said I floud with her'" Documentation vents of the control	3rd timeasked to use of told her he would get or)Resident #38 (name) way for CNA #9 to help (name) helped (Resident bedpanLPN #6 (name) tionmad, and talked to'maybe I was raising my Kept focusing on it, over feel bad, maybe I was too was lacking to indicate ately reported to facility concern the resident in the early morning of N #6 having yelled and				
	3/7/11 for CNA # was working the	ounseling form" dated #9 indicated "Employee night of alleged verbal by Resident #38 (name).				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE S	ETED	
		155777	B. WIN		- <u>-</u> -	04/15/20	011
	PROVIDER OR SUPPLIER		•	1750 S	ADDRESS, CITY, STATE, ZIP CODE CREASY LANE	•	
	SPRINGS HEALTH			LAFAYE	ETTE, IN47905		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI			(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	DATE
	1 ^	n of suspected verbal					
		was immediately					
	suspended pendi						
		ound to have not been					
	^	leged verbal abuse en LPN #6 (name) and					
		me)Employee has been					
	`	serviced regarding					
		nd fully understands the					
		mediately any suspected					
	incidents in the future" Resident #38's record was reviewed on						
	4/15/11 at 10:20	a.m. The record					
		dent was admitted to the					
	l *	. The record indicated					
		her own person and was					
	alert and oriented	1 x 3.					
	A nurses' note sig	gned by LPN #6, dated					
	3/6/11 at 12:15 a	.m., indicated					
	"Resident put c	call light on to go to					
	restroom. When	male aide entered she					
	did not want him	help her (sic)- writer					
		assist- Attempted to					
	1 1	e aide was an employee-					
		very defensive +					
		g foul language- accusing					
	-	at her + using foul					
	') her- writer left room					
		id (sic) from another hall					
		aid (sic) helped her she					
	· ` `	sic) could be in her room					
	anytime"						

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Facility ID:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777		(X2) MULTIPLE A. BUILDING B. WING	00	COM	TE SURVEY SPLETED 5/2011	
	PROVIDER OR SUPPLIER		STREE 1750	ET ADDRESS, CITY, STATE, ZIP S CREASY LANE AYETTE, IN47905	- CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	A nurses' note daindicated "Write be tearful this mode services) her took tearfulness" During an intervices Director 11:20 a.m., she in resident's room to as she was a new indicated it was a shared with her to related to LPN #6 resident reported in her manner of The SSD indicated reported the resident the ED. She CNA were suspectives tigation. She behavior and into was inappropriate.	ted 3/6/11 at 9:00 a.m., rer observed (resident) to orning. S/S (Social ay et (and) notified of ew with the Social (SSD) on 4/15/11 at adicated she went into the pointroduce herself to her ly admitted resident. She at that time the resident the concern she had 6. She indicated the the nurse had been harsh talking and was loud. The ed she immediately lent's concern to the DHS indicated the LPN and	1	CROSS-REFERENCED TO TH	IE APPROPRIATE	1
	During an intervi Director on 4/15/ indicated CNA # the resident was	ew with the Executive 11 at 11:45 a.m., she 9 "should have reported so upset immediately; bunseled him for not				
	reporting."	AMISSION IMIT TOT HOT				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
		155777	A. BUII B. WIN			04/15/2	011
			D. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				CREASY LANE		
CREASY	SPRINGS HEALTH	1 CAMPUS		LAFAYE	ETTE, IN47905		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION DATE
IAG		ey and procedure titled	+	IAG	Dirichi.e.,		DATE
	"Abuse and negle						
	_	vided by the ED on					
		.m., identified as current					
		ogy Health Services					
		mented processes in an					
		a comfortable and safe					
	•	erbal abuse-may include					
		estured language that					
	,	ing and derogatory terms					
	to the resident/patient or within their						
	hearing distance, to describe residents,						
	regardless of their age, ability to						
	•	isability i. Staff to					
	-	sodeTrainingprovide					
		employees through					
	_	vith ongoing training					
		ing will include, but is					
	not limited toid	lentification of abuse or					
	neglecthow to j	provide protection for					
	residentshow to	o identify those residents					
	at risk for abusin	g other residentshow					
	toreport incide	nts of actual or suspected					
	abuse or neglect.	"					
	3.1-28(c)						
F0226 SS=D	written policies and mistreatment, neg	evelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property.					
	Based on record facility failed to	review and interview, the follow their abuse y and procedure by failing	FO)226	CORRECTIVE ACTIONAII employees are educated to t facility's policies and procedu regarding abuse and neglect	ıres	05/15/2011
					<u> </u>		

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					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155777	B. WIN	IG		04/15/2	011
NAME OF	PROVIDER OR SUPPLIEF	,		STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF	FROVIDER OR SUFFLIER			1750 S	CREASY LANE		
	SPRINGS HEALTI			<u> </u>	ETTE, IN47905		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	-	TAG		la i a a	DATE
		dent of verbal abuse,			resident rights at the time of in New Employee Orientation		
		harassment between a			The facility policy requires	1.	
	staff member and	d a resident was			screening of employees, train	ning	
	immediately rep	orted and investigated.			of employees, prevention ste		
	The alleged staff	member worked the			and identification steps that		
	remainder of the	shift after the incident			include prompt reporting of a		
		leficient practice affected			resident allegations of abuse		
		gations reviewed, and 1			an allegation is made the firs		
		ent in a supplemental			priority is immediate provisio safety for residents that may		
					include moving the resident t		
	sample of 1 reviewed for abuse.				another room, providing		
(Resident #38)				one-on-one monitoring if			
					appropriate, or suspending the		
Findings include:				suspected employee(s) pend			
					outcome of investigation. An		
	Review of an ab	use allegation provided			investigation is immediately initiated as well as prompt		
		Director on 4/14/11 at			reporting to the physician, fa	milv	
	_ ·	ated the following:			member, Triogy managemer	-	
	1.10 p.m., maree	wed the following.			and state agencies. All reside		
	A "fox/incident r	report" dated March 6,			at the time of admission are		
		-			informed of the facility's zero		
		Brief description of			tolerance for abuse standard		
		ent #38's name) reported			how residents may report an	•	
		6/6/11 that the night shift			concerns they experience where the concerns they experience where the concerns the concerns they experience where the concerns the concer	III C	
	nurse (LPN #6)	last night yelled at her			Executive Director and Director	tor of	
	because (the resi	dent) requested a female			Health Services did take		
	staff member to	help (the resident) to the			appropriate action immediate	ely	
		nstead of the male staff			when informed of the resider		
	` ′	wered her call light.			allegations by suspending th		
		nt asked the nurse (LPN			nurse and CNA working on the shift at the time of the incider		
		resident's) room (the			and initiating an immediate	III.	
	· '	, ,			investigation into the residen	t's	
	· ·	he nurse did not leave at			allegations. The incident was		
	_	umentative Resident			reported timely to the Indiana		
		ot want this nurse caring			State Department of Health.	The	
	for her againIn				CNA was counseled and		
	takenthe night	nurse and male CNA			in-serviced on 3-7-11 regard	ing	

li '		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED				
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		
	155777	B. WIN	G		04/15/201	1
NAME OF PROVIDER OR SUPPLIE	3		STREET A	DDRESS, CITY, STATE, ZIP CODE		
			1	CREASY LANE		
CREASY SPRINGS HEALT	H CAMPUS		LAFAYE	TTE, IN47905		
` '	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
,	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
` ′	sk a female CNA to			resident abuse and expresse		
provide care for	the resident the remainder			that he fully understood the r to report immediately any	ieeu	
of the night shift	t to alleviate the resident's			suspected incidents in the fu	ture	
concern about h	aving a male caregiver.			IDENTIFY OTHER		
Immediately up	on the resident reporting			RESIDENTSThe Social Serv	rice	
1 .	ne Social Services			Director on 3-6-11 did intervio		
	the SSD contacted the			other alert and oriented resid		
· '	th Services (DHS) who			in the health center and aske		
	` '			they had any concerns with he staff had treated them or with		
	ursing staff. The DHS			their care. No other residents		
immediately contacted the night nurse				expressed any mistreatment	· I	
I *	e male CNA (CNA #9)			concern to the Social Service		
and they were be	oth placed on suspension			Director. MEASURES/SYST	EMIC	
pending comple	tion of a full investigation			CHANGESEducation for staf		
of the incident	Preventative measures			initiated on 3-6-11 for staff fro		
takenThe DHS	S contacted the Executive			all departments regarding the		
Director (ED) to	apprise her of the			facility's policies and procedu on abuse and neglect and the		
` ′	rn. The ED contacted the			importance of any staff mem		
	son to make him aware of			becoming aware of a residen		
				concern to promptly report th		
	ncerns, the facility's			the Executive Director and/or		
	protect the resident and			the Director of Health Service		
	restigation into the			appropriate steps can be take		
resident's concer	rns. An in-service on the			per facility policy to protect the resident that include suspendent		
abuse and negle	ct policies of the campus			the suspected employee(s)	alling	
was initiated for	all staff on 3-6-11The			pending outcome of		
Social Services	Director and ED met with			investigation. All department		
the resident at se	eparate times the			staffs will be in-serviced on the		
	-11 and the resident had			abuse and neglect policies a	nd	
	and was smiling an			procedures including the		
	them and showed no			requirement to promptly repo any allegations.MONITORIN		
1				CORRECTIVE ACTIONEach		
signs of distress				month at Resident Council		
				residents are educated regar	ding	
	summary dated March			their rights including the right		
11, 2011, signed	by the ED was provided			be free from any mistreatmen		
on 4/14/11 at 4:3	30 p.m., by the ED and			including abuse and neglect	and	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER:			00	(X3) DATE COMPI	
		155777	A. BUII			04/15/2	
		.30777	B. WIN	_	PPPPG GWW GW ==	5 + 15/2	
NAME OF I	PROVIDER OR SUPPLIER	8		1	ADDRESS, CITY, STATE, ZIP CODE CREASY LANE		
CREASY	SPRINGS HEALTH	H CAMPUS			ETTE, IN47905		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)		TAG			DATE
		Social Service Director			asked if they have any conce Any resident allegations of	erns.	
		all alert and oriented			suspected abuse will be		
		11 on the hallway where			immediately investigated and		
	· ·	(46) worked to ensure no			appropriate and required act		
		vere concerned with			will be implemented including immediate suspension of the		
		No other residents			suspected employee(s) pend		
		cerns with any staff			outcome of the investigation		
		g multiple investigative			investigations are document		
		the resident at different			and reported immediately to	-1::	
		ifferent individuals this			Trilogy division support inclu outcome of the investigation		
	resident was con	sistent inrecollection of			action steps taken. Additiona		
	the events that happened early in the morning of 3-6-11. At approximately				all allegatons of abuse are	,,	
					reported to the QA committe		
	12:15 am the res	ident placedcall light			monthly and the QA committ		
	on. The male Cl	NA (CNA #9) on duty			will review each allegation to ensure the facility policy and		
	entered the room	to assist (the resident).			procedure was followed. Sho		
	When (the reside	ent) realized he was a			negative trends be noted the		
	man, the resident	t requested that a female			committee will report those		
	1	s she was uncomfortable			findings to Trilogy Division Support for additional trainin	a or	
	with a male care;	giver. The male CNA			corrective action.	y UI	
		ent that he understood					
	and he left the ro	oom and informed his					
		ne charge nurse (LPN #6)					
		ges that the male CNA					
	I -	the resident's request and					
		and the charge nurse					
		at the charge nurse entered					
	_	o talk with the resident.					
		ntains that the charge					
	nurse began talki	_					
	1	oud voice, telling the					
		resident) needed to					
	`	CNA to provide care for					
		cause he was scheduled					
FORM CMS-2	2567(02-99) Previous Version		R2L311	Facility 1	ID: 012285 If continuation s	heet Pa	ge 32 of 86

PRINTED: 05/19/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE		
11.15 12.11.	or continuenton	155777	- 1	LDING		04/15/2	
		100111	B. WIN	_	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				CREASY LANE		
CREASY	SPRINGS HEALTH	H CAMPUS		1	ETTE, IN47905		
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TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		are for the resident and					
		he resident indicates that					
		g the conversation did the					
		arse offer to assist the					
		athroom herself The					
		at the charge nurse					
		argumentative with her					
		ver status, allowing the					
		escalate in both tone and					
		ident asked the charge					
		er room and the charge					
	nurse did not immediately comply with						
	_	sing an increase in the					
	resident's anxiou						
		rsation the charge nurse					
		m and sought a female					
	•	resident was distressed					
	1	his point. The charge					
		vestigative interview that					
		ake the resident to the					
	· ·	ver the resident remains					
		did not. The charge					
		she did not yell at the					
		resident has remained					
		e nurse did yell at her					
	and was argumen						
	· -	erviews were conducted					
		mbers working to provide					
		ent on the night shift the					
		The male and female					
		I for the resident the night					
		oted in investigative					
		ne resident expressed					
	concern to them	about how the charge					

012285

NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS (X4) ID SIMMARY STATEMENT OF DEFICINCIES (BACH DEFICINCY) MUST BE PERCEDED BY FULL REGULATORY OR LISC IDMINITYING INFORMATION) REFER ADDRESS, CITY, STATE, ZIP CODE (TYP) AND SCREASY LANG OR CORRECTION. (X5) (RECEIVED IN THE PROPERTY OF COMPLETION.) REFER ADDRESS, CITY, STATE, ZIP CODE (TYP) AND SCREASY LANG OR CORRECTION. (X5) (RECEIVED IN THE PROPERTY OF COMPLETION.) REFER ADDRESS, CITY, STATE, ZIP CODE (TYP) AND SCREASY LANG OR CORRECTION. (X5) (RECEIVED IN THE PROPERTY OF COMPLETION.) REFER ADDRESS, CITY, STATE, ZIP CODE (TYP) AND SCREASY LANG OR CORRECTION. (X5) (RECEIVED IN THE PROPERTY OF COMPLETION.) REFER ADDRESS, CITY, STATE, ZIP CODE (TYP) AND SCREASY LANG OR CORRECTION. (X5) (RECEIVED IN THE PROPERTY OF COMPLETION.) REFER ADDRESS, CITY, STATE, ZIP CODE (TYP) AND SCREASY LANG OR CORRECTION. (X5) (RECEIVED IN THE PROPERTY OF COMPLETION.) REFER ADDRESS, CITY, STATE, ZIP CODE (TYP) AND SCREASY LANG OR CORRECTION. (X5) (RECEIVED IN THE PROPERTY OF COMPLETION.) REFER ADDRESS, CITY, STATE, ZIP CODE (TYP) AND SCREASY LANG OR CORRECTION. (X5) (RECEIVED IN THE PROPERTY OF COMPLETION.) REFER ADDRESS, CITY, STATE, ZIP CODE (TYP) AND SCREASY LANG OR CORRECTION. (X5) (RECEIVED IN THE PROPERTY OF COMPLETION.) REFER ADDRESS, CITY, STATE, ZIP CODE (TYP) AND SCREASY LANG OR CORRECTION. (X5) (X5) (RECEIVED IN THE PROPERTY CORRECTION. (X5) (RECEIVED IN THE PROPERTY OF COMPLETION.) REFER ADDRESS, CITY, STATE, ZIP COMPLETION. (X5) (CORRECTION.) REFER ADDRESS, CITY, STATE, ZIP COMPLETION. (X5) (CORRECTION.) REFER ADDRESS, CITY, STATE, ZIP CORRECTION. (X5) (CORRECTION.) REFER ADDRESS, CITY, STATE, ZIP COMPLETION. (X5) (COMPLETION.) REFE	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	00	COME	ESURVEY PLETED	
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neglect and he was allowed to return to work. Based on all the investigative interview, the campus had no alternative but to terminate the nurse based on her failure to honor the resident's rights to have an environment free of harassment and intimidation that provides the resident choice about treatment and care and dignity" A statement dated March 6, 2011 from		immediately any	concerns regarding				
work. Based on all the investigative interview, the campus had no alternative but to terminate the nurse based on her failure to honor the resident's rights to have an environment free of harassment and intimidation that provides the resident choice about treatment and care and dignity" A statement dated March 6, 2011 from		violation of resid	lent's rights or abuse or				
interview, the campus had no alternative but to terminate the nurse based on her failure to honor the resident's rights to have an environment free of harassment and intimidation that provides the resident choice about treatment and care and dignity" A statement dated March 6, 2011 from		neglect and he w	as allowed to return to				
but to terminate the nurse based on her failure to honor the resident's rights to have an environment free of harassment and intimidation that provides the resident choice about treatment and care and dignity" A statement dated March 6, 2011 from		work. Based on	all the investigative				
failure to honor the resident's rights to have an environment free of harassment and intimidation that provides the resident choice about treatment and care and dignity" A statement dated March 6, 2011 from		interview, the car	mpus had no alternative				
have an environment free of harassment and intimidation that provides the resident choice about treatment and care and dignity" A statement dated March 6, 2011 from		but to terminate t	the nurse based on her				
and intimidation that provides the resident choice about treatment and care and dignity" A statement dated March 6, 2011 from		failure to honor t	he resident's rights to				
choice about treatment and care and dignity" A statement dated March 6, 2011 from		have an environm	nent free of harassment				
dignity" A statement dated March 6, 2011 from		and intimidation	that provides the resident				
A statement dated March 6, 2011 from		choice about trea	tment and care and				
		dignity"					
		A statement date	d March 6, 2011 from				
STATES Indicated intestable 130 (name)			· · · · · · · · · · · · · · · · · · ·				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777		ĺ	LDING	NSTRUCTION 00	(X3) DATE: COMPL 04/15/2	ETED	
	PROVIDER OR SUPPLIER		1	1750 S	DDRESS, CITY, STATE, ZIP CODE CREASY LANE TTE, IN47905	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	(The resident) streemale for her property and the propert	was lacking to indicate ately reported to facility concern the resident in the early morning of N #6 having yelled and					

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Facility ID:

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPLI		
AND PLAN	OF CORRECTION	155777		LDING	00	04/15/20	
		100777	B. WIN		DDDEGG CITY GTATE ZID CODE	04/10/20	,,,
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE CREASY LANE		
CREASY	SPRINGS HEALTH	I CAMPUS		1	ETTE, IN47905		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
IAG		· · · · · · · · · · · · · · · · · · ·	_	TAG	DEFICIENCY)		DATE
	1 1	ounseling form" dated					
	3/7/11 for CNA #9 indicated "Employee was working the night of alleged verbal						
		by Resident #38 (name).					
	1 ^	of suspected verbal					
		was immediately					
	suspended pendi						
		ound to have not been					
	^	leged verbal abuse					
	altercation between LPN #6 (name) and						
	Resident #38 (name)Employee has been counseled and inserviced regarding						
		d fully understands the					
		mediately any suspected					
	incidents in the fi	uture					
	Resident #38's re	cord was reviewed on					
	4/15/11 at 10:20	a.m. The record					
	indicated the resi	dent was admitted to the					
	facility on 4/4/11	. The record indicated					
	the resident was	her own person and was					
	alert and oriented	1 x 3.					
		11 1 DN 1// 1 1 1					
	·	gned by LPN #6, dated					
	3/6/11 at 12:15 a						
	_	eall light on to go to					
		male aide entered she					
		help her (sic)- writer					
		assist- Attempted to					
	_	aide was an employee-					
		very defensive +					
		g foul language- accusing					
	-	at her + using foul					
	[language c (with)	her- writer left room					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155777	A. BUII	LDING	00	COMPL 04/15/2	
		100777	B. WIN			04/15/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CREASY	SPRINGS HEALTH	I CAMPLIS			CREASY LANE ETTE, IN47905		
					-112, 1147 000		215
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		id (sic) from another hall	1				
		id (sic) helped her she					
		sic) could be in her room					
	anytime"	sie) could be in not room					
	, with vittle						
	A nurses' note da	ted 3/6/11 at 9:00 a.m.,					
		ter observed (resident) to					
		orning. S/S (Social					
		ay et (and) notified of					
	tearfulness"	wy vv (with) noviniva or					
	During an interview with the Social						
	~	r (SSD) on 4/15/11 at					
		ndicated she went into the					
		o introduce herself to her					
		ly admitted resident. She					
		at that time the resident					
		he concern she had					
		6. She indicated the					
	resident reported	the nurse had been harsh					
		talking and was loud.					
		ed she immediately					
		lent's concern to the DHS					
	1 ^	indicated the LPN and					
	CNA were susper						
		ne indicated the LPN's					
		eraction with the resident					
		e. She indicated no staff					
		resident's concern about					
	LPN #6 to her.						
	During an intervi	iew with the Executive					
	~	'11 at 11:45 a.m., she					
		9 "should have reported					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155777	B. WIN			04/15/2011
			-		ADDRESS, CITY, STATE, ZIP CODE	ļ
NAME OF F	PROVIDER OR SUPPLIER			1750 S	CREASY LANE	
	SPRINGS HEALTH	I CAMPUS			ETTE, IN47905	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE
		so upset immediately;				
	that is why we co	ounseled him for not				
	reporting."					
	An undated polic	ey and procedure titled				
	"Abuse and negle	•				
	_	rided by the ED on				
	, ,	.m., identified as current				
		ogy Health Services				
		~ .				
		mented processes in an				
	•	a comfortable and safe				
		erbal abuse-may include				
		estured language that				
		ing and derogatory terms				
	to the resident/pa	tient or within their				
	hearing distance,	to describe residents,				
	regardless of the	ir age, ability to				
	comprehend or d	isability i. Staff to				
	resident- any epi	sodeTrainingprovide				
		employees through				
	_	vith ongoing training				
		ing will include, but is				
		lentification of abuse or				
		provide protection for				
		•				
		o identify those residents				
		g other residentshow				
	-	nts of actual or suspected				
	abuse or neglect.	•••				
	2 1 29(a)					
	3.1-28(a)					
			_			

NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS X(4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; At a summary provider. STREET ADDRESS, CTY, STATE, ZIP CODE 1750 S CREASY LANE LAFAYETTE, INA7905 ID PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COMPRETED TO THE APPROPRIATE	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Skin conditions; Activity pursuit; Activity pursuit;			155777			04/15/2011	
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit;				STREET 1750 S	CREASY LANE		
Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on interview, observation and record review, the facility failed to complete comprehensive assessments for self-administration of medications and a indwelling catheter for 1 of 1 resident F0272 CORRECTIVE ACTION1 - The Elimination Circumstance Assessment had been completed for resident #21 for his in and out catheterization but had not again been completed for the Foley	CREASY S (X4) ID PREFIX TAG F0272 SS=D	SUMMARY S (EACH DEFICIEN REGULATORY OR The facility must of periodically a comstandardized reproduced resident's fur A facility must make assessment of a resident's fur A facility must make assessment of a resident's fur A facility must make assessment of a resident's fur Continence patterns Communication; Vision; Mood and behavior Psychosocial well-Physical functionir Continence; Disease diagnosis Dental and nutritions Skin conditions; Activity pursuit; Medications; Special treatments Discharge potentian Documentation of regarding the addition performed through protocols; and Documentation of Based on interview, the complete compresion of the self-administration indwelling cather	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) conduct initially and prehensive, accurate, oducible assessment of nctional capacity. Ke a comprehensive esident's needs, using the ne State. The assessment ast the following: demographic information; e; s; or patterns; being; ng and structural problems; and health conditions; onal status; es and procedures; al; summary information itional assessment n the resident assessment participation in assessment ew, observation and the facility failed to behensive assessments for on of medications and a ter for 1 of 1 resident	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CORRECTIVE ACTION1 - T Elimination Circumstance Assessment #21 for his in and catheterization but had not a been completed for the Foley	The 05/15/201 pleted dout again y	
who self-administered medications and 1 of 3 residents with indwelling catheters, and failed to ensure comprehensive assessments were accurate related to catheter anchored three days later. The resident is currently without a Foley catheter. 2A - A care plan correctly noting the resident's alteration in skin integrity and pressure risk for		of 3 residents win	th indwelling catheters, sure comprehensive		later. The resident is currentl without a Foley catheter. 2A care plan correctly noting the resident's alteration in skin	ily A e	

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Event ID:

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155777	B. WIN			04/15/2	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	₹		1			
CDE ACX	CODINCE LIEALTI	LCAMPUC		1	CREASY LANE		
CREASY	SPRINGS HEALTI	H CAMPUS		LAFAYE	ETTE, IN47905		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	pressure ulcers 1	of 1 resident with			resident #21 was put in place		
	pressure ulcer as	ssessments in a sample of			4-12-11. This resident discha	•	
	10. (Residents #				on 4-20-11. 2B - The medica		
	10. (Residents II	10 and 1121).			were removed from the room	n of	
	F: 1: . 1 1				resident #21 on 4-11-11.	UTC4	
	Findings include	2.			IDENTIFY OTHER RESIDEN - Currently no other residents		
					have Foley catheters. Any	5	
	1. Resident #18's	s clinical record was			admissions with a Foley cath	neter	
	reviewed on 4/14	4/11 at 8:35 A.M. The			will be assessed during the	.0.0.	
	resident was adn	nitted with diagnoses			admission assessment proce	ess.	
		but were not limited to,			2A - Assessments for all		
	· ·				admission/readmissions will		
	urinary retention	and clostridium difficile.			be reviewed in the Clinical		
					Meeting Monday through Fri	-	
	A physician's or	der dated 3/24/11			the morning following admiss		
	indicated "Fold	ey x (times) 6 daysDx			for accuracy of documentation	on.	
	(diagnosis) reten	ntion"			2B - All other health center	1	
					resident's rooms were audite and no other medications we		
	An "Elimination	Circumstance			found at the bedside.	16	
		· ·			MEASURES/SYSTEMIC		
		nd Intervention" form			CHANGES1 - Licensed		
	dated 3/25/11 in	dicated "in et (and) out			nursing staff will be in-service	ed on	
	cath				the need for and proper		
	(catheterization)	approach/intervention			completion of the Elimination	ı	
	undate use toile	et (circled)urinal			Circumstance form prior to		
		umentation was lacking			anchoring or removing a Fole	•	
	1 ` ′	•			catheter. 2A - Assessments	for all	
		sessment for the Foley			admission/readmissions will		
	catheter.				be reviewed in the Clinical	da.	
					Meeting Monday through Frie	-	
	Interview on 4/1	4/11 at 9:30 A.M. with			the morning following admiss for accuracy of documentation		
	RN #2 indicated	"I think the assessment			2B - Licensed nursing staff w		
	should have been	n done."			in-serviced regarding the		
		 			importance of observing for a	any	
	Intomvices 4/1	4/11 of 10:20 A M			medications at the bedside of	•	
		4/11 at 10:20 A.M. with			resident. If observed, medica	ations	
		Health Services indicated			are to be removed and the n	urse	
	the resident "pro	bably didn't have an			will evaluate the resident for		
	assessment for tl	he Foley catheter." She			self-administration of the		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/15/2011
	PROVIDER OR SUPPLIER		1750 S	ADDRESS, CITY, STATE, ZIP CODE CREASY LANE ETTE, IN47905	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
		ssment should be to insertion and after ey catheter.		medications. Additionally, ar insert is being prepared for the admission packet for resider and family members educated them that residents may not medications at the bedside without a self-administration assessment being completed. Residents and families will be asked not to bring medication the resident. If the family bring items for resident use, included over-the-counter items, they be asked to take the items to nurses' station first for assessment. MONITORING CORRECTIVE ACTIONDITE of Health Services or design will monitor daily Monday the Friday at the Clinical Meeting physician orders related to Fourtheaters and will review the Elimination Circumstance. Assessment to ensure proposition. An admission checklist will be utilized to ensure documents on assessments. A daily aud the resident room will be completed to ensure that no medications are at the bedsivithout a self-administration assessment having been completed. Audit results will reported monthly to the QA committee for three months evaluate the effectiveness of measures/systemic changes implemented. If any negative trends are noted the committee will recommend changes in interventions and	he ints ing have d. De ins to ings ding will to the ctor inge rough grall foley in the color ings ding will be to fithe de ings die color ings ding will be to fithe de ings ding will be to fithe ding will be

012285

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155777	B. WIN			04/15/2	011
			р. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8		1	CREASY LANE		
CREASY	SPRINGS HEALTH	-I CAMPUS			ETTE, IN47905		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG		_	DATE
					extend the monthly review an additional three months to er		
					effectiveness of new	isure	
					interventions.		
	2 A. The clini	ical record for					
	Resident # 21 was reviewed on						
	04/11/2011 at	10:05 a.m.					
	Dingnosas ina	ludad but ware not					
	_	luded, but were not					
	limited to, per	nile cancer with total					
	penectomy, de	epression, congestive					
		nd history of alcohol					
		na mistory of areonor					
	abuse.						
	A						
	PRESSURE/	STASIS/ARTERIAL/					
	DIABETIC U						
	ASSESSMEN	T," dated 03/29/2011					
	indicated an a	rea of deep pink					
		on the sacrum. The					
		dicated a stage 1					
	pressure ulcer	measuring 5 cm					
	(centimeters)	long by 3 cm wide					
	with no depth.						
	with no acpui.	•					
	An "ASSESSI	MENT REVIEW					
	AND CONSII	DERATIONS," dated					
		ndicated, "Skin					
	breakdown ris	k potential:					
	None"						

NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A Minimum Data Set (MDS) assessment, dated 04/05/2011, indicated the resident had one stage 2 pressure ulcer and was at risk for	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M A. BUII		NSTRUCTION 00	(X3) DATE : COMPL	ETED
NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A Minimum Data Set (MDS) assessment, dated 04/05/2011, indicated the resident had one stage 2 pressure ulcer and was at risk for			155777	- 1			04/15/2	011
CREASY SPRINGS HEALTH CAMPUS (X4) ID PREFIX TAG A Minimum Data Set (MDS) assessment, dated 04/05/2011, indicated the resident had one stage 2 pressure ulcer and was at risk for LAFAYETTE, IN47905 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A Minimum Data Set (MDS) assessment, dated 04/05/2011, indicated the resident had one stage 2 pressure ulcer and was at risk for	NAME OF P	PROVIDER OR SUPPLIER		•	1			
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A Minimum Data Set (MDS) assessment, dated 04/05/2011, indicated the resident had one stage 2 pressure ulcer and was at risk for	CREASY	SPRINGS HEALTH	H CAMPUS		1			
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A Minimum Data Set (MDS) assessment, dated 04/05/2011, indicated the resident had one stage 2 pressure ulcer and was at risk for								(X5)
A Minimum Data Set (MDS) assessment, dated 04/05/2011, indicated the resident had one stage 2 pressure ulcer and was at risk for						(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
assessment, dated 04/05/2011, indicated the resident had one stage 2 pressure ulcer and was at risk for	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG		ME.	DATE
developing pressure ulcers. During an interview on 04/12/11 at 9:40 a.m., RN # 2 indicated that a resident who was admitted to the facility with a stage 1 pressure ulcer should have been identified at risk for skin break down. During an interview on 04/15/2011 at 9:15 a.m., the DHS (Director of Health Services) indicated the assessment for skin breakdown on 03/29/2011 was incorrect and should have identified the resident at risk for skin breakdown since he was admitted with a stage 1 pressure ulcer. 2 B. An "ASSESSMENT REVIEW AND CONSIDERATIONS," dated 03/29/2011, indicated, "Self Medication:No plan of care is necessary at this time"	TAG	A Minimum D assessment, daindicated the real pressure ulcedeveloping pressure ulcedeveloping an interposition of the second of t	Pata Set (MDS) ated 04/05/2011, esident had one stage er and was at risk for essure ulcers. Erview on 04/12/11 at # 2 indicated that a was admitted to the stage 1 pressure ulcer een identified at risk down. Erview on 04/15/2011 The DHS (Director of es) indicated the er skin breakdown on the stage 1 pressure ulcer een identified at risk down. Erview on 04/15/2011 The DHS (Director of es) indicated the er skin breakdown on the stage 1 ESSMENT REVIEW DERATIONS," dated dicated, "SelfNo plan of care is		TAG	DEFICIENCY		DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 04/15/2	LETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LANE LAFAYETTE, IN47905				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	EΕ	(X5) COMPLETION DATE
	03/29/2011, ir inhale (SIC) (for hours) ii (twheezing" A physician's 04/01/2011, ir (Milk of Magnetimeters) proposed (every day) proconstipation A MDS assess 04/05/2011, ir was cognitive day of the serior of the serio	endicated, "MOM enesia) 60 cc (cubic endicated) now & qd end (as needed) (for) ." sment dated, endicated the resident ely intact. rations on 04/11/2011 end 10:45 a.m., had one bottle of esia and one Ventolin endedside. The resident					
	_	erview on 04/11/2011 RN # 5 indicated					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777				LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/15/2	ETED
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	l	
					CREASY LANE ETTE, IN47905		
	SPRINGS HEALTH			<u> </u>	= 1 1 E, IN47905		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	medications sl	nould not have been					
	at a resident's	bedside unless the					
	resident had b	een assessed for safe					
	self medicatio	n administration.					
	During an inte	erview on 04/11/2011					
	at 10:50 a.m.,						
	· ·	10 indicated the					
	resident shoul	d not have					
	medications st	cored at the bedside					
	until he had be	een assessed for safe					
		n administration.					
	An undated po	olicy titled					
		OOCUMENTATION					
		lmission Nursing					
		nd Data Collection"					
		by the Executive					
	_	1/14/2011 at 1:45 p.m.					
		licated, "The					
	assessment sh						
	identification						
		sment, observation					
	and review of						
		that may contribute					
	to additional c	•					
	medical declir	_					
	concerns"	ic of safety					
	concerns						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777		(X2) MULTIP A. BUILDING B. WING		STRUCTION 00	(X3) DATE S COMPL 04/15/2	ETED	
	PROVIDER OR SUPPLIER		17:	50 S C	DDRESS, CITY, STATE, ZIP CODE CREASY LANE ITE, IN47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		Έ	(X5) COMPLETION	
F0279 SS=D	A facility must use assessment to der resident's comprel. The facility must do care plan for each measurable object a resident's medic psychosocial needs comprehensive as. The care plan must are to be furnished resident's highest mental, and psych required under \$44 would otherwise be but are not provide exercise of rights or right to refuse treat Based on intervite facility failed to care plans were disolation, a pacer tube for 2 of 2 reat a sample of 10. (Findings include 1a. Interview on during an initial of Resident #27 was for "MRSA (met).	the results of the velop, review and revise the nensive plan of care. evelop a comprehensive resident that includes tives and timetables to meet al, nursing, and mental and its that are identified in the sessment. St describe the services that it to attain or maintain the practicable physical, osocial well-being as 83.25; and any services that it e required under §483.25 and due to the resident's under §483.10, including the timent under §483.10(b)(4). The timent under sempleted related to maker, and a gastrostomy sidents with care plans in Residents # 23 and #27). 4/11/11 at 6:50 A.M., tour, LPN #3 indicated is in respiratory isolation		G	CROSS-REFERENCED TO THE APPROPRIAT	o the on tes, ding not sion. on tident pus 1.	DATE 05/15/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

R2L311

Facility ID:

012285

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155777	B. WIN			04/15/2	011
		<u>I</u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	₹		1	CREASY LANE		
CREAS	SPRINGS HEALTI	H CAMPUS		1	ETTE, IN47905		
				<u> </u>			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					pacemaker as of 3-30-11 on	the	
	Resident #27's c	linical record was			Admission Data		
	reviewed on 4/1	1/11 at 10:10 A.M.			Collection Assessment form.		
	Resident #27 wa				Resident #23 was admitted t campus on 3-31-11. The	o tne	
					gastrostomy tube (G-tube) w	200	
	~	included, but were not			noted on the admission	as	
	limited to, pacen	naker and recent			assessment and noted "do n	ot	
	pneumonia.				use though" and the physicia		
					not prescribe any additional		
	A hospital admis	ssion note dated 3/28/11			orders for interventions as no	oted	
	1 -	ent methicillin-resistant			on the 3-31-11 nurse's		
		aureus pneumonia."			notes. When contacted again	า	
	Staphylococcus	aureus pheumoma.			regarding any requested		
					interventions the physician o		
	1 ^	1/19/11, 3/31/11, 4/1/11,			4-12-11 did order a dry dress		
	4/5/11, 4/6/11, a	nd 4/7/11 indicated			to the peg tube site. A care p		
	documentation v	vas lacking related to a			was updated on 4-13-11 and resident's gastrostomy tube		
		ress the resident being in			removed on 4-15-11. IDENT		
	isolation.				OTHER RESIDENTS1a - All		
	isolation.				residents' care plans were		
	1/1	0/11 . 0 45 4 35 . 11			reviewed to ensure the need	for	
		2/11 at 9:45 A.M. with			isolation was included in the		
	LPN #1 indicate	d the resident should have			resident's care plan.1b - All		
	had a care plan f	for isolation.			residents' care plans were		
					reviewed for any residents w		
	Interview on 4/1	4/11 at 10:20 A.M. with			pacemakers. Care plans are		
		Health Services indicated			place and orders are noted.		
					No other current residents ha	ave	
		be documented on the			a gastrostomy tube. If any residents are admitted with a	,	
	care plan.				gastrostomy tube the campu		
					provide care per the care pla		
	1b. A nursing ad	mission assessment dated			developed on physician prote		
	3/30/11 indicated	d "pacemaker			and orders.		
	(circled)"	•			MEASURES/SYSTEMIC		
	(0110104)				CHANGES1a - All departme	nts	
	C 1 1 1 1	1 2 / 2 1 / 1 1 1 4 / 1 / 1 1 1 4 / 5 / 1 1			staff will be in-serviced on th	е	
	1 ^	1 3/3 1/11, 4/1/11, 4/5/11,			policies and procedures for		
	4/6/11, and 4/7/1				isolation precautions and pro		
	documentation v	vas lacking to address the			procedures based on the lev	el of	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155777	B. WIN	IG		04/15/2	011
NAME OF I	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	ROVIDER OR SUPPLIER			1750 S	CREASY LANE		
	SPRINGS HEALTH				ETTE, IN47905		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG			DATE
	care of the reside	ent having a pacemaker.			isolation for the resident. 1b Licensed nursing staff will be		
					in-serviced on the proper	·	
	Interview on 4/1	2/11 at 9:45 A.M. with			completion of the Admission	Data	
	LPN #1 indicate	d the resident should have			Collection Assessment form		
	had a care plan f	or a pacemaker.			including pacemakers. 2 -		
	·	•			Licensed nursing staff will		
	2 Resident #23's	s clinical record was			be in-serviced on the proper	Б. (
		2/11 at 9:50 A.M. The			completion of the Admission Collection Assessment form	Data	
		nitted with diagnoses			including gastrostomy tubes.		
		_			MONITORING CORRECTIV		
	1	but were not limited to,			ACTIONDirector of Health		
	burns and benign prostatic hypertrophy.				Services or designee will rev	iew	
					any residents with isolation		
	A nursing admis	sion assessment dated			precautions, pacemakers an		
	3/31/11 indicated	d "NutritionG-tube			gastrostomy tubes (g-tubes)		
	present"				ensure appropriate interventi are implemented as part of the		
					ongoing QA process. Audit re		
	Care plans dated	3/31/11, 4/1/11, and			will be reported monthly to th		
	_	documentation was			committee for three months t		
		a care plan to address			evaluate the effectiveness of		
	the care of the re	-			measures/systemic changes implemented. If any negative		
	gastrostomy tube	•			trends are noted the QA	;	
	gastrostomy tube				committee will recommend		
	Intomia 4/1	2/11 of 11.20 A M			changes in interventions and		
		2/11 at 11:20 A.M. with			extend the monthly review a	า	
		d the resident should have			additional three months to er	sure	
	had a care plan f	or the gastrostomy tube.			effectiveness of new		
					interventions.		
	Interview on 4/1	5/11 at 9:10 A.M. with					
	the DHS indicate	ed the admission					
	assessment inclu	ded the initial care plan					
	but it only indica	ates what the resident has					
	· ·	care should be. She					
		e plans were temporary					
	and not complete						
	and not complete	. .					
	1						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777		A. BUI	LDING	ONSTRUCTION 00	(X3) DATE S COMPL 04/15/2	ETED	
NAME OF F	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE CREASY LANE		
CREASY	SPRINGS HEALTH	I CAMPUS		1	ETTE, IN47905		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	3.1-35(a) 3.1-35(b)(1)						
F0281 SS=D		ded or arranged by the professional standards of					
	Based on obse	rvation, interview	F0	281	CORRECTIVE ACTIONThe		05/15/2011
	and record rev	iew, the facility			nurse was immediately instru on proper technique and	oted	
		e wound care was			acknowledged her error and		
		rding to professional			acknowledged understanding	g of	
	•	uality for 1 of 1			the proper technique on 4-12-11. IDENTIFY OTHER		
	_	-			RESIDENTSAll residents wit	:h	
		wed for wound			current dressing orders will b	е	
	dressing chang	ges in a sample of 10			observed during licensed nu	rse	
	residents (Resi	ident # 21).			competencies on dressing changes.		
	Findings inclu	de:			MEASURES/SYSTEMIC CHANGESLicensed nurses be in-serviced on dressing changes and infection control		
	The clinical re	cord for Resident #			practices when performing	,,	
		ed on 04/11/2011 at			dressing changes.MONITOR	RING	
	10:05 a.m.	ca on o 1/11/2011 at			CORRECTIVE ACTIONThe Director of Health Services of	.r	
	10.03 a.iii.				designee will observe a rand		
					selected nurse performing	,	
	Diagnoses incl	luded, but were not			dressing changes three time		
	limited to, pen	ile cancer with total			weekly for four weeks to ens correct technique (if	ure	
	penectomy, de	pression, congestive			residents in-house require		
	_	nd history of alcohol			dressing changes) and then	every	
	abuse.	J			other week for four weeks ar	nd	
					then monthly as part of the ongoing QA process. Any nu	ırse	
	A physician's	coonitulation dated			observed not following prope		
		recapitulation, dated			technique during the dressin	g	
	· ·	dicated, "Wet to			change will be immediately	oner	
	Dry Drsg (dres	ssing) to (R) (right)			stopped and instructed on pr procedure and will receive	opei	
	groin BID (tw	ice a day)"			corrective action. Observatio	n	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155777		LDING	00	04/15/2	
		100777	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0 17 1072	
NAME OF F	PROVIDER OR SUPPLIER			1	CREASY LANE		
	SPRINGS HEALTH			1	ETTE, IN47905		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
	A physician's of 04/11/2011, in "Clarification drsg (dressing) strips soaked (saline) - cover to fit - BID (two RN # 2 was obtreatment to Regroin area on (a.m. Normal sover 4 inch by squares. Steril push the gauze wound and swound and swound and swound and swound and swound and swound area sterile Q-tip. covered with a sterile Q-tip.	order, dated dicated, n: (R) (right) groin (P) = (is) pack (with) with) NS (normal (with) coversite. Cut wo times daily)" oserved providing esident # 21's right (D4/12/2011 at 10:00) saline was poured 4 inch gauze the Q-tips were used to be squares into the ab the wound bed. In the date of the wound bed with			results will be reported month the QA committee for three months to evaluate the effectiveness of the measures/systemic changes implemented. If any negative trends are noted the QA committee will recommend changes in interventions and extend the monthly review at additional three months to er effectiveness of new interventions.	e I	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777		(X2) MUL: A. BUILDI B. WING		NSTRUCTION 00	(X3) DATE S COMPL 04/15/2	ETED	
	PROVIDER OR SUPPLIER			1750 S (DDRESS, CITY, STATE, ZIP CODE CREASY LANE TTE, IN47905		
	SPRINGS HEALTH- SUMMARY S' (EACH DEFICIENCE REGULATORY OR the physician's include instruct the wound using gauze squares. Would have exsaline flushes to incisional wound the wound using gauze squares. Would have exsaline flushes to incisional wound the wound the wound the saline flushes to incisional wound the saline flushes to incision. An undated portion of the saline standard of the saline standard of the saline standard of the saline standards for the saline sta	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) To order did not etions for cleansing ing 4 inch by 4 inch She indicated pected the RN to use to cleanse an ind. Tryiew on 04/12 /2011 RN #2 indicated she did the wound by uze squares into the Dicy titled, "General Dressing Changes" by the DHS on 2:15 p.m. The policy follow doctors ons for treatment" Wet to dry dressing	l PR	1750 S (CREASY LANE	TE	(X5) COMPLETION DATE
	9:15 p.m. The "Remove soil	procedure indicated, iled dressingIrrigate ormal saline"					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR 00 COMPLETE					
155777			A. BUII			04/15/2	
		100777	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				CREASY LANE		
_	SPRINGS HEALTH				ETTE, IN47905		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓΕ	COMPLETION DATE
		cation, titled, "JOB					D.H.E
	•						
SPECIFIC ORIENTATION CHECKLIST" provided by the							
		•					
		ector on 04/15/2011					
		ndicated RN # 2					
	received traini	-					
	wound/dressin	g changes on					
	05/06/2010.						
	3.1-35(g)(1)						
F0282		ded or arranged by the					
SS=D		ovided by qualified persons					
	in accordance with each resident's written plan of care.						
	•	ew and record review, the	F0	282	CORRECTIVE ACTIONThis		05/15/2011
	facility failed to	ensure a physician's order			resident had been on Vancomycin		
	was followed rela	ated to Vancomycin (an			since 3-14-11. A physician's was obtained to discontinue		
	, , , , , , , , , , , , , , , , , , ,	istration for 1 of 1			Vancomycin order. A stool		
		acomycin ordered in a			specimen was collected and determined negative for C-di		
	sample of 10. (Re	esident #18).			4-21-11. An order was obtain		
	Finding to 1 4.				on 4-22-11 to discontinue the	9	
	Findings include				isolation procedures. IDENT OTHER RESIDENTSAll curr		
	Resident #18's cl	inical record was			residents physician's orders		
		1/11 at 8:35 A.M. The			Medication Administration	_	
		nitted with diagnoses			Records have been reviewed MEASURES/SYSTEMIC	1.	
		but were not limited to,			CHANGESLicensed nursing	staff	
		ve pulmonary disease			will be in-serviced to review t	:he	
	and clostridium difficile (a bacteria).				importance of ensuring a physician's order is obtained	and	
					documented for all medication		
		form dated 4/11/11			changes. MONITORING		
	•	esident) continues on			CORRECTIVE ACTIONThe Director of Health Services or		
	Vanco (vancomy	cin) 2.5 cc PO (by				"	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

R2L311 Facility ID: 012285

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155777	B. WIN			04/15/20	U11
NAME OF	PROVIDER OR SUPPLIE			1	ADDRESS, CITY, STATE, ZIP CODE		
00540	/ ODDINIOO IE A T			1	CREASY LANE		
CREASY	/ SPRINGS HEALTI	H CAMPUS		LAFAYE	ETTE, IN47905		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	+	TAG	designee will monitor physici	ion	DATE
	· ' '	ice a day) for C-Diff			orders Monday through Frida		
	1 '	icile). Res stools are			the Clinical Meeting to ensur		
		r - Has been on Vanco			physician orders are followed		
	1	you want stop date"			ensure that antibiotic orders		
	1	response was "D/C			been properly entered on the Medication Administration	•	
	(discontinue) 4/2	24/11."			Record. If the Director of Hea	alth	
					Services observes that order		
	1	der dated 4/11/11			have not been properly		
	indicated "D/C V	Vanco on 4/24/11."			documented the nurse failing	, ,	
					follow policy and procedure versive corrective action. The		
		dministration Record			Director of Health Services v		
	dated April 2011	indicated "3/31/11			report findings to the QA		
	Vancomycin 1 G	im (gram) vial.			committee monthly for three		
	Reconstitute c (v	with) 20 ml (milliliters)			months. The QA committee very review and if negative trends		
	sterile H2O (wat	ter) & give 2.5 ml (125			noted the QA committee will	o ale	
	mg [milligrams]) PO BID x (times) 14			recommend changes in		
	days" Further	review indicated the			interventions and extend the		
	vancomycin had	been given from 4/1/11			monthly review an additional		
	to 4/10/11. A not	tation indicated "D/C			three months to ensure effectiveness of new		
	4/11/11." Docum	nentation was lacking			interventions.		
	related to the var	ncomycin having been					
	given after 4/10/	11.					
	Interview on 4/1	4/11 at 9:30 A.M. with					
	RN #2 indicated	the vancomycin had been					
	discontinued and	had not been given after					
	4/10/11.	•					
	3.1-35(g)(2)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155777 04/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1750 S CREASY LANE CREASY SPRINGS HEALTH CAMPUS LAFAYETTE, IN47905 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Each resident must receive and the facility F0309 must provide the necessary care and services SS=D to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. CORRECTIVE ACTIONResident Based on interview and record review, the F0309 05/15/2011 #27 was admitted to the campus facility failed to ensure a resident received on her current stay on 3-30-11 necessary care and services related to and the resident was admitted to pacemaker parameters and information for hospice care on 4-7-11. A care plan was in place related to her 1 of 1 resident with a pacemaker in a pacemaker as of 3-30-11 on the sample of 10. (Resident #27). Admission Data Collection Assessment form. Per Findings include: investigation of prior medical records the resident had a pacemaker check every four Resident #27's clinical record was months and the next check was reviewed on 4/11/11 at 10:10 A.M. The due in the month of April. When resident was admitted with diagnoses advised of the physician's previous order for a pacemaker which included, but were not limited to, check in April, the resident's pacemaker and non-ischemic responsible party requested that arteriosclerotic heart disease. no further pacemaker checks be conducted due to the resident's hospice status and a physician's A hospital discharge summary dated order was obtained to discontinue 3/30/11 indicated "...pacemaker wire in pacemaker checks. The resident the right ventricle...final expired on 4-22-11. IDENTIFY diagnoses:...pacemaker..." OTHER RESIDENTSAll residents care plans were reviewed for any residents with pacemakers. Care Review of a physician's recapitulation plans are in place and orders are dated April 2011 indicated documentation noted per physician order. was lacking related to pulse parameters MEASURES/SYSTEMIC for notifying the physician. CHANGESLicensed nursing staff will be in-serviced regarding the policy and procedures Review of the clinical record indicated for completion of the Admission there was no information available related Data Collection Assessment form to the type of pacemaker or upper and including pacemakers and

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
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NAME OF I	PROVIDER OR SUPPLIER	8			CREASY LANE		
CREASY	SPRINGS HEALTH	H CAMPUS			ETTE, IN47905		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	·		DATE
	Interview on 4/1. LPN #1 indicated what type of pactor what pulse limpacemaker. She standard with a limbacemaker what pulse limpacemaker. She standard with a limbacemaker with a limbacemaker with a limbacemaker with a limbacemaker. She standard with a limbacemaker w	limits of the pacemaker. 2/11 at 9:45 A.M. with d she was unaware of emaker the resident had nits were set for the stated "55 or 60 or above 2/11 at 11:55 A.M. with nator indicated the facility olicy related to caring for pacemaker. ncott's Nursing a Edition, 2009 indicated be checked for one			(EACH CORRECTIVE ACTION SHOULD BE	ers. E iew ers to ons etor that olicy care ee o the ree vill are	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU OO COMPLE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	l	
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CREASY	SPRINGS HEALTH	I CAMPUS		LAFAYE	ETTE, IN47905		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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		· · · · · · · · · · · · · · · · · · ·	<u> </u>	TAG	DEFICIENCY)		DATE
F0314 SS=D	Based on the coma resident, the faci resident who enter pressure sores do sores unless the ir demonstrates that a resident having precessary treatment healing, prevent in sores from develop Based on observation record review, the provide intervent ulcers and failed appropriate treatment resulting in development ulcers and failed appropriate treatment ulcers and failed appropriate treatment ulcers in (Resident #27). Findings include: On 4/11/11 at 6:5 tour with LPN #1 identified as having coccyx and left be incontinent, and the resident was on a mattress lying on On 4/11/11 at 9:2	ation, interview, and e facility failed to ions to prevent pressure to provide the ment for pressure ulcers lopment of two Stage II or 1 of 5 residents with a sample of 10. 60 A.M., during an initial 1, Resident #27 was ang an "open area" on her uttock, being being on hospice. The a pressure reducing	F0	314	CORRECTIVE ACTIONReside #27 was admitted on her curstay on 3-30-11. All other assessments, care plans and documents dated prior to that date as noted in the finding a not relevant to the current state On the resident's admission assessment and care plan date. 3-30-11 under the Skin Plan Care the following intervention were implemented: turn and reposition for comfort and with care; prevent skin from touch skin; elevate heels off surfact use lift sheet to reposition in provide pressure relieving deto bed; ensure resident is cleand dry; provide padding for casts, splints, etc; ensure adequate hydration; observe observe nutritional intake; provide provide provide pressure resident is cleand splints. Due to the resident's health status and prognosis for resident's family elected hos	dent rent d t t are ay. ated of ons th ning e; bed; evice ean labs; ovide - a,	DATE 05/15/2011
		55 A.M. with LPN #1, s observed in bed lying			services for the resident on 4-7-11. The hospice nurse ar Director of Health Services b noted on 4-8-11 that a chang	oth	
					noted on 4-0-11 that a chang	ic III	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
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CREASY	SPRINGS HEALTI	H CAMPUS		LAFAYE	ETTE, IN47905		
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	on her back. The	e resident was assisted to			the resident's pressure redu		
	turn to her side.	There was a wound			mattress was delayed due to		
	observed on her	coccyx and on her left			resident's significant pain wi mobility that was charted. Th		
		vas a white substance over			nursing staff did turn and	ic	
		ere was no dressing in			reposition the resident per th	ne	
		•			plan of care. The facility poli		
	1 ^	neasured the wounds as			provided in the survey indica		
	follows:				that turning and repositionin		
					not routinely documented as	this	
	Coccyx - 0.9 by	0.6 cm. LPN #1 indicated			is a normal nursing standard		
	it was "just an o	pen area. Excoriation."			practice that will be performe		
		4 by 1.2 cm. LPN #1			accordance with the residen		
		"an open area from			care plan. The Calazime cre		
		-			was an appropriate treatmen		
	_	sture. It doesn't look like			the resident's partial thickne pressure ulcers that were les		
	pressure."				than 0.1 cm and were not de		
					puncture wounds. The staff	•	
	LPN #1 applied	Calazime cream (a			selected a cream treatment		
		cream) to both wounds.			an occlusive dressing due to	the	
	There was no dr				son's reporting that the resid	lent	
	There was no ar	essing applied.			had a history of sensitivity to		
		1 601 : : 1: . 1			adhesives. Calazime is a zir		
		be of Calazime indicated			based barrier cream. IDENT		
	"skin protectant	•			OTHER RESIDENTSCurrer		
	oxideuses help	s prevent diaper			residents with pressure area		
	rashexternal us	se onlydo not use on			were reviewed and treatmer		
	deep or puncture	•			and care plans were approp for the pressure areas.	nate	
	acop or puncture				MEASURES/SYSTEMIC		
	Pagidant #2712 -	linical record was			CHANGESLicensed nursing	staff	
					will be in-serviced on the	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
		1/11 at 10:10 A.M. The			prevention of pressure areas	s and	
	resident was adn	nitted with diagnoses			appropriate treatment of pre		
	which included,	but were not limited to,			areas. MONITORING		
	cerebrovascular	accident, urinary			CORRECTIVE ACTIONDire		
	incontinence, recent pneumonia, spinal				of Health Services or design		
	stenosis, right parietal infarct, and				will monitor interventions an	d	
		miciai illiaici, allu			treatments of residents with		
	osteoporosis.				pressure areas three times	200	
	I		1		weekly for four weeks and the	IE[]	i

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777		(X2) MULTIPLE A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/15/2011	
	PROVIDER OR SUPPLIER		STREE 1750	S CREASY LANE AYETTE, IN47905	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
	An admission massessment dated resident was coglimited one-persibed mobility, tracontinent of bowrisk for developing pressure ulcers, lead a turning and region at turning and region at turning and region bed mobility limited assistance use, was occasion continent of bowdeveloping pressure ulcers, lead a turning and region bed mobility limited assistance use, was occasion continent of bowdeveloping pressure ulcers, lead a pressure ulcers, lead a pressure ulcers, lead and repositioning admis 3/30/11 indicated short-term memoral flow of speech, whad a pressure region indicated by cheep can be a position of the lead of the lea	inimum data set (MDS) I 1/7/11 indicated the nitively intact, required on physical assistance for nsfer, and toilet use, was rel and bladder, was at ng pressure ulcers, had no nad pressure reducing and chair, and was not on positioning program. I assessment dated 3/4/11 Ident was cognitively upervision of one person and transfer, required e of one-person for toilet nally incontinent of urine, rel, was at risk for the ulcers, had no had a pressure reducing d, was not on a turning		every week for four weeks then monthly as part of the ongoing QA process. All stissues including pressure of are reported to Trilogy Clin Support each week by the Director of Health Services the trends are monitored at action steps implemented in negative trends are observed and the QA common reviews Skin Care Manage for residents including presulcers and also monitors for negative trends and if those observed will work in conjumith Trilogy Clinical Supposimplement interventions.	and exin ulcers uical exand if exed. ittee ement exement

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE SUR COMPLETI		
ANDILAN	or connection	155777	A. BUI			04/15/201	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	CREASY LANE		
CREASY	SPRINGS HEALTH	I CAMPUS		1	ETTE, IN47905		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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IAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	l ′	lift sheet to reposition in ssure relieving device to					
	bed (circled)"	ssure refleving device to					
	bea (encica)						
	A resident care p	lan dated 1/19/11 and					
	_	indicated "Potetential					
	1 ^	n Skin Integrity related					
	` ′	other: recent surgery, orif					
	(open reduction i	internal fixation) of left					
	lower leg for frac	ctured fibula and a					
	fractured ribint	erventions: examine skin					
	daily for signs of						
		acourage and assist to					
	_	on q2hrs (every two					
		s needed). Avoid					
		re reducing mattress on					
	_	ducing cushion to					
	1	in assessment by licensed					
	nurse"						
	A nurses' note da	ted 4/10/11 at 2:00 P.M.					
		open areas on bilt					
		x area. Area on (R) (right)					
	l ' -	easures 1 cm (centimeter)					
	x 1 cm et (and) (1	L) (left) coccyx 2.5 x 2					
	cm. Hospice call	ed et will need re-called					
		mergency messages able					
		(name) notified. Res					
	'	urned/repositioned) q20					
	l ' -)." Nurses' notes 3/30/11					
	"	indicated documentation					
	_	ed to the resident having					
	been turned and	repositioned.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		155777	A. BUI B. WIN	LDING IG		04/15/2011	
	PROVIDER OR SUPPLIER SPRINGS HEALTH			1750 S	ADDRESS, CITY, STATE, ZIP CODE CREASY LANE ETTE, IN47905		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID		(X:	5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DAT	Е
	Skin tracking she	eets indicated:					
	Left buttock:						
	4/10/11 "Other S	kin Impairment					
	AssessmentSta	ge IIPresent on					
	admission N (circ	cled)location: (L)					
	buttockLength	1.5 Width 1.2 Depth <					
	` ′	Brown/p (pink)Tx					
	` ′	oSee pressure ulcer					
	sheet.						
	4/12/11 "Pressure	e/Stasis/Arterial /Diabetic					
	Ulcer Assessmen	tHighest stage IIL					
	(length) 1.5 W (v	vidth) 1.2 D (depth) <					
	0.1Color/tissue	type/percent/location:					
		nt treatment Calazine					
	` ′	Current preventative					
		(turn) et R (reposition) as					
	tol (tolerated)"						
	Соссух:						
	4/10/11 "Other S	kin Impairment					
	AssessmentSta	•					
		cled)location: (R)					
	,	Length 1 cm Width 1 cm					
	-	n) 0.1R (red)Tx					
	_	oSee purple pressure					
	ulcer sheet.						
	4/12/11 "Pressure	e/Stasis/Arterial /Diabetic					
		itHighest stage IIL					
		dth) 1 D (depth) <					
	5 /	, \ 1 /				<u>!</u>	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

R2L311

Facility ID:

012285

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
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CREASY	SPRINGS HEALTH	I CAMPUS		1	ETTE, IN47905		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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1710		type/percent/location:	+	1710	<u> </u>		DATE
		nt treatment Calazine					
	1 ^ ^	Current preventative					
	()	(turn) et R (reposition) as					
	tol (tolerated)"						
	A physician's ord						
		me Crm (cream). Apply					
	` ′	outtock sacral area TID					
	`	y) et PRN p (after) ea					
	(each) incontiner	it episode"					
	A Treatment Adn	ninistration Record dated					
		ated the Calazime cream					
	_	lied as ordered on the					
	1	1/11. Further review					
	indicated weekly	skin checks had been					
	completed on 4/2	2/11 and 4/9/11 but there					
	was no document	tation related to the					
	condition of the s	skin.					
	l . com	. 1 1 . 1 . 1 . 1 . 1 . 1 . 1 . 1					
	I -	ent sheet dated 4/13/11,					
	1 1	ical Care Coordinator					
	· ·	ed as current, indicated vas lacking related to					
		sitioning the resident					
	every two hours.	_					
	creis two nours.						
	Interview on 4/12	2/11 at 8:55 A.M. with					
	LPN #1 indicated	d the Calazime cream					
	was being used e	very two hours on the					
	resident's pressur	e ulcers.					
	Interview on 4/12	2/11 at 9:45 A.M. with					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
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NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				1	CREASY LANE	
CREASY SPRINGS HEALTH CAMPUS		1 CAMPUS		LAFAYE	ETTE, IN47905	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		d the resident was being				
	1	itioned every 2 hours but				
	there was no doc					
		vere no barrier creams				
	being used prior					
	developing the pr	ressure ulcers.				
	Interview on 4/1	2/11 at 9:45 A.M. with				
		nator indicated the				
		was being used on the				
	l ⁻	ecause the family said the				
	resident was aller	rgic to tape.				
	Review on 4/13/	11 at 12:00 P.M. of an				
		policy and procedure				
		administrator and titled				
		sessment Guideline"				
		illed residents shall have				
		sessment review that				
	1	hange in the risk factors				
	impacting skin in	•				
	impacting skin ii	···- D···· ·J····				
	Review on 4/13/	11 at 12:00 P.M. of a				
	facility policy an	d procedure dated 1/06				
	and revised 4/08	•				
		d titled "Weekly Skin				
		deline" indicated "Upon				
		mitting nurse shall				
		f the admission orders				
	_	ssment. The order shall				
	I -	in assessment on (day of				
	· ·	areas of skin impairment.				
	· ·	npairment (see wound				
		g area of impairment (see				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/15/2011				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LANE LAFAYETTE, IN47905					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	weekly skin chec	he nurse completing the ck shall indicate the ber (0, 1, 2) and their						
	facility policy an provided by the a "Turning and Re "Turning and rep routinely docume practice will be r	11 at 12:00 P.M. of a d procedure dated 10/07 administrator and titled positioning" indicated positioning is not centedExceptions to this noted if the resident is on ng and repositioning						
	undated facility provided by the a "Basic Wound In"Basic wound	11 at 12:00 P.M. of an policy and procedure administrator and titled aterventions" indicated treatment:Maintain d. Cover and protect"						
F0365 SS=D	provides food prep meet individual ne Based on observa interview, the fact resident received diet as ordered by deficient practice	eives and the facility pared in a form designed to eds. ation, record review, and cility failed to ensure a la mechanically altered by the physician. This effected 1 of 2 residents rapeutic diets in a sample	F0365	CORRECTIVE ACTIONWhen Director of Health Services was made aware of the resident receiving the incorrect diet the food was removed and replayith the correct food texture 4-12-11 the resident's diet to card was corrected immedia	was os/13/2011 ne nced . On nay			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
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			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	CREASY LANE		
CREASY SPRINGS HEALTH CAMPUS			1	ETTE, IN47905			
				L			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
of 10. (Resident #13)				when the Director of Food	-fit		
				Services became aware to re			
	Findings include	::			the proper diet of mechanica with ground meat and thin liq		
					On 4-12-11 an in-service was		
	During an observ	vation on 4/11/11 at 10:02			held with nursing staff to ens		
	_	13 was observed in bed			staff knew how to review diet		
	1				orders when serving resident	t	
	1	on his bedside table. The			meals to ensure the diet serv		
		f an egg omelet with			correct. Dining Services staff		
	ham, 2 pieces of	toast, and a sausage			were also in-serviced on 4-12	2-11	
patty. The meat on the tray was not					regarding the importance of reviewing the tray card when		
	ground.				chefs are plating the meal to		
					ensure all foods served are in		
	During an observation on 4/12/11 at 12:15				accordance with the diet orde		
	_	13 was observed in the			IDENTIFY OTHER		
	1 *	ne resident was served his			RESIDENTSAn audit was		
					conducted on 4-12-11 of all		
		neal consisted of a			resident diets by the Director		
		on a bun with lettuce and			Food Services. All other residuate ware entered into the		
	tomato, french fi	ries, and a bowl of			diets were entered into the d tray card correctly and match		
	pineapple chunk	S.			the physician's order.	ieu	
					MEASURES/SYSTEMIC		
	During an interv	iew with the Director of			CHANGESNursing staff will		
		(DHS), on 4/12/11 at			be in-serviced on the tray ca	rd	
		ndicated Resident #13's			system and proper observati		
					the resident's plated meal an		
		echanical soft, ground			ensuring it matches the resid		
		quids. She indicated			diet order. The Director of Fo Service implemented a chan		
	"that is not a me	chanical soft tray."			communication with the Ther	•	
					Department regarding diet	ару	
	During an interv	iew with Chef #1 on			change orders initiated by sp	eech	
	4/12/11 at 12:35	p.m., he indicated the			therapy. Therapy is now prov		
		ald have of identifying a			a copy of diet order changes		
	1 -	hen serving the meal			both nursing and dining servi		
		at the tray card. He			and the Director of Food Ser		
		not aware the resident			is confirming with nurses the		
					physician's order for diet when confirmed by the atten-	dina	
	had an order for	a mechanical soft diet			when communed by the attent	uiiig	

l l		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155777	B. WIN	IG		04/15/2	011
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CREASY SPRINGS HEALTH CAMPUS				LAFAYE	ETTE, IN47905		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	nt. He indicated he served			physician. The Consultant Dietitian will audit each new		
		indicated on the tray			resident's diet when complet	ina	
	card. He indicat	ed the resident had not			the comprehensive assessm	•	
	been receiving a	mechanical soft diet and			to ensure the diet order and		
	he did not know	how the tray card and the			card match. MONITORING		
	resident's ordere	d diet could be so far off.			CORRECTIVE ACTIONAn a		
					of diet orders and tray cards be completed each month fo		
	Resident #13's re	ecord was reviewed on			months to ensure diet orders		
	4/11/11 at 10:40 a.m. Diagnoses for Resident #13 included, but were not limited to, diabetes mellitus, dementia,				tray cards match. The audit		
					results will be reported to the		
					Committee each month. The	QA	
	CVA (stroke), and a history of dysphagia.				committee will review and if negative trends are noted the	<u>-</u> ∩Δ	
	` ′′	ated the resident was			committee will recommend	3 W (
		e facility on 2/25/11 with			changes in interventions and		
		rie) cardiac ADA			extend the monthly review a		
	,	(mechanical soft) ground			additional three months to er	isure	
	1 ` ′	` , •			effectiveness of new interventions.		
	meat et (and) thi	ii iiquius.			interventions.		
	A physician's or	der dated 2/28/11					
		-mechanical soft, ground					
	meat et (and) thi	. •					
	incat ct (and) thi	ii iiquius					
	Δ nhysician's or	ders recapitulation for					
	1 * *	cated Resident #13's diet					
	1 * '						
	thin liquids"	cal soft, ground meat &					
	uiiii iiquius						
	A meal tray cord	for Resident #13 dated					
	1	ed the resident's diet was a					
	1 '						
	1	nt carbohydrate), NAS					
	(no added salt).						
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	, the second					
	1	etary communication"					
	form provided by	y the DHS on 4/12/11 at					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER				ONSTRUCTION 00	(X3) DATE S COMPL		
		155777	A. BUI B. WIN	LDING		04/15/2011	
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				CREASY LANE		
CREASY SPRINGS HEALTH CAMPUS					ETTE, IN47905		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		ated "diet order: 2000		1110			DITTE
	-	iaccomments (located					
	` ′	corner of the form):					
	_	ground meat thin					
	liquids"						
	J						
	During an intervi	iew with the DHS at the					
	_	communication form was					
	-	licated the form was					
	provided to the D	Dietary Manager by the					
	nursing staff, to	ensure the resident					
	received the diet	ordered by the physician.					
	During an intervi	iew with the Dietary					
	_	/11 at 1:45 p.m., he					
	indicated he rece	ived a copy of the dietary					
	communication f	form from the nursing					
		ed the ordered diet was					
	<u>-</u>	n the diet order line of					
		on form. He indicated					
		oft ground meat was					
	written on the co						
		t have "just missed it."					
		resident had been					
		stent carbohydrate, no					
	added salt diet pr	rior to today.					
	A11:	1 1.41.2000 (241					
		cedure, dated 2009, titled					
	•	als/ trays and tray cards"					
	-	Dietary Manager on					
	_	.m., identified as current					
		als will be efficiently and					
	-	outed to individualseach					
	individual will ha	ave a tray card that					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155777	B. WINC			04/15/20	011
NAME OF B	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
					CREASY LANE		
CREASY	SPRINGS HEALTH	I CAMPUS		LAFAYE	TTE, IN47905		
(X4) ID		TATEMENT OF DEFICIENCIES	•	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
F0371 SS=F	includes the individual number, diet order followed to ensure serveddining set and print up-to-de A policy and provided by the Id 4/15/11 at 8:40 a indicated "Diet physician" 3.1-21(a)(3) The facility must - (1) Procure food from considered satisfal local authorities; at (2) Store, prepare, under sanitary cornidered satisfal local authorities; and record reversal failed to ensure and prepared in related to imput frozen food and washing and contaminated. practice had the	cedure, dated 2009, titled eral information" Executive Director on .m., identified as current is will be ordered by the com sources approved or ctory by Federal, State or ind iditions rvation, interview iew, the facility iew iew, the facility iew iew, the facility iew iew, the facility iew, the facility iew iew iew, the facility iew iew iew, the facility iew	F03	TAG	CORRECTIVE ACTIONOn 4-11-11 the food on the floor the walk-in freezer was immediately placed on the shelves in the freezer. The Director of Food Services reviewed the policy and procedure for proper storage food with the kitchen staff including chefs and dining services assistants on 4-11-1 The surveyor observation of #1 occurred on 4-12-11 not 4-13-11 as noted in the findin The Director of Food Service 4-12-11 informed Chef #1 an of the surveyor's observation and concerns with glove chain	of 1. Chef g. s on d #2 s nging	DATE 05/15/2011
	i mamga meru				and hand washing. The kitch	en	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

R2L311 Facility ID: 012285

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SERILING SAME OF PROVIDER OF SUPPLIER	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS (PACH) DETECTION TAG During the initial kitchen tour on 04/11/2011 at 6:55 a.m., two boxes of vegetables, two boxes of chicken were stored on the floor of the walk in freezer. During an interview on 04/11/2011 at 7:00 a.m., the dietary manager indicated the food had been delivered to the facility on 04/09/2011. He indicated he did not work on the week end when the food was delivered, but the food should not have been stored on the freezer floor. Observations of food preparation began on 04/13/2011 at 11:30 a.m. During the observation period, Chef # I was observed touching a box of Angus beef and plastic food wrap with gloved hands. He opened a bulk package of cheese and removed a stack of cheese slices. He then opened the box of	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	A. BUILDING		COMPLETED
NAMILOP PROVIDER OF SUPPLIER CREASY SPRINGS HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES LAFAYETTE, IN47905 DUTING the initial kitchen tour on 04/11/2011 at 6:55 a.m., two boxes of vegetables, two boxes of beef patties, and four boxes of chicken were stored on the floor of the walk in freezer. During an interview on 04/11/2011 at 7:00 a.m., the dictary manager indicated the food had been delivered to the facility on 04/09/2011. He indicated he did not work on the week end when the food was delivered, but the food should not have been stored on the freezer floor. Observations of food preparation began on 04/13/2011 at 11:30 a.m. During the observation period, Chef # 1 was observed touching a box of Angus beef and plastic food wrap with gloved hands. He opened a bulk package of cheese and removed a stack of cheese slices. He then opened the box of			155777		04/15/2011		
CREASY SPRINGS HEALTH CAMPUS CREASY SPRINGS HEALTH CAMPUS COMPLETING PREFIX TAG During the initial kitchen tour on 04/11/2011 at 6:55 a.m., two boxes of vegetables, two boxes of beef patties, and four boxes of chicken were stored on the floor of the walk in freezer. During an interview on 04/11/2011 at 7:00 a.m., the dictary manager indicated the food had been delivered to the facility on 04/09/2011. He indicated he did not work on the week end when the food was delivered, but the food should not have been stored on the freezer floor. Observations of food preparation began on 04/13/2011 at 11:30 a.m. During the observation period, Chef # 1 was observed touching a box of Angus beef and plastic food wrap with gloved hands. He opened a bulk package of cheese and removed a stack of cheese slices. He then opened the box of				_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
SUMMARY STATEMENT OF DEFICIENCIES PREFIX CACIT DEFICIENCY MUST BY PIRCEDED BY PULL REGULATORY OR I SCIDENTIFYING INFORMATION) TAG STATEMENT AND CORRECTION STATEMENT AND COMPLETENCY MANAGEMENT AND CO	NAME OF F	PROVIDER OR SUPPLIER			1750 S	CREASY LANE	
During the initial kitchen tour on 04/11/2011 at 6:55 a.m., two boxes of vegetables, two boxes of beef patties, and four boxes of chicken were stored on the floor of the walk in freezer. During an interview on 04/11/2011 at 7:00 a.m., the dietary manager indicated the food had been delivered to the facility on 04/09/2011. He indicated he did not work on the week end when the food was delivered, but the food should not have been stored on the freezer floor. Observations of food preparation began on 04/13/2011 at 11:30 a.m. During the observation period, Chef #1 was observed touching a box of Angus beef and plastic food wrap with gloved hands. He opened a bulk package of cheese and removed a stack of cheese slices. He then opened the box of	CREASY SPRINGS HEALTH CAMPUS				LAFAYE	ETTE, IN47905	
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During the initial kitchen tour on 04/11/2011 at 6:55 a.m., two boxes of vegetables, two boxes of beef patties, and four boxes of chicken were stored on the floor of the walk in freezer. During an interview on 04/11/2011 at 7:00 a.m., the dietary manager indicated the food had been delivered to the facility on 04/09/2011. He indicated he did not work on the week end when the food was delivered, but the food should not have been stored on the freezer floor. Observations of food preparation began on 04/13/2011 at 11:30 a.m. During the observation period, Chef # 1 was observed touching a box of Angus beef and plastic food wrap with gloved hands. He opened a bulk package of cheese and removed a stack of cheese slices. He then opened the box of						(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
During the initial kitchen tour on 04/11/2011 at 6:55 a.m., two boxes of vegetables, two boxes of beef patties, and four boxes of chicken were stored on the floor of the walk in freezer. During an interview on 04/11/2011 at 7:00 a.m., the dietary manager indicated the food had been delivered to the facility on 04/09/2011. He indicated he did not work on the week end when the food was delivered, but the food should not have been stored on the freezer floor. Observations of food preparation began on 04/13/2011 at 11:30 a.m. During the observation period, Chef # 1 was observed touching a box of Angus beef and plastic food wrap with gloved hands. He opened a bulk package of cheese and removed a stack of cheese slices. He then opened the box of	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
beef. He walked over to the fryer and touched the handle of the fryer	TAG	During the init 04/11/2011 at of vegetables, patties, and for were stored on in freezer. During an inte at 7:00 a.m., the indicated the fedelivered to the 04/09/2011. He not work on the food was delived should not have freezer floor. Observations of began on 04/12 During the observations of began on 04/12 During the observations of Angus I wrap with glow opened a bulk and removed a slices. He then beef. He walk	tial kitchen tour on 6:55 a.m., two boxes two boxes of beef ar boxes of chicken a the floor of the walk rview on 04/11/2011 he dietary manager food had been be facility on the indicated he did not be week end when the food the been stored on the servation period, between the food wed hands. He package of cheese in stack of cheese in opened the box of feed over to the fryer		TAG	staff were immediately instruction proper technique and acknowledged an understant of the proper technique for his washing policy and glove used IDENTIFY OTHER RESIDENTSCorrective action noted apply to all residents of health center. MEASURES/SYSTEM CHANGESAN audit tool is becreated and implemented for audits of food storage areas completed weekly by the Direct of Food Services or designed Dining Services staff will be in-serviced by Division Di Support regarding food storage and glove and hand washing MONITORING CORRECTIV ACTIONAudits of food storage will be completed weekly for months and then monthly as of the ongoing QA process. Consultant Dietitian will audit meal preparation/plating once every week for four weeks at then once every two weeks for eight weeks and then once every month for three month part of the QA process. The committee will review and if negative trends are noted the committee will recommend changes in interventions and extend the monthly review and additional three months to ereffectiveness of new	ding and e

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE S COMPL		
THETETAL	or conduction	155777	A. BUILDING			04/15/2	
NAME OF F			B. WIIN	_	ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER			1	CREASY LANE		
CREASY SPRINGS HEALTH CAMPUS				LAFAYE	ETTE, IN47905		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	COMPLETION DATE
	basket. He ret	urned to the grill and					
		amburgers. A few					
		ne removed French					
	fries from the	fryer and took them					
	to the serving	counter. He touched					
	the fries and o	btained a food					
	temperature. I	He recorded the					
	temperature in	the log book, then					
	opened a box of	of hamburgers and					
	placed the patties on the grill. After						
	the patties wer	e placed on the grill,					
	he removed hi	s gloves and washed					
	his hands. Thi	is was the first					
	observation of	washing hands and					
	changing glove	es after multiple					
	times of contai	mination.					
	Chef # 2 was o	observed removing					
	lettuce and ton	natoes from the					
	refrigerator wi	th gloved hands. He					
	placed the foo	d on the counter, then					
	obtained trays	and plates. He					
		food prep area and					
	_	and tomatoes onto					
		washing his hands or					
	changing glove	es.					
	mi p.	r 1 1					
	· ·	lanager was observed					
	touching multi	iple surfaces with his					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPI		
		155777	A. BUI B. WIN	LDING IG		04/15/2	2011
NAME OF I	PROVIDER OR SUPPLIER		D. 1111	_	DDRESS, CITY, STATE, ZIP CODE		
				1	CREASY LANE		
	SPRINGS HEALTH			LAFAYE	ETTE, IN47905		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	1	(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
	gloved hands.	The surfaces					
	included refrig	gerator doors, the					
	food prep cour	nter, bowls, a knife					
	and a package	of cheese slices. He					
	reached into h	is pants pocket, then					
		knife and opened the					
		e. He did not change					
	gloves or wash	n hands between					
	touching surfa	ces and touching					
	food.						
	During an inte	erview on 04/12/2011					
	at 11:52 a.m.,	the Dietary Manager					
	indicated all st	taff should wash their					
	hands and cha	nge gloves between					
	touching surfa	ces and food and					
	before and after	er touching raw and					
	ready-to-eat fo	oods.					
	An undated po	olicy, titled, "Storage					
	Procedures" w	as provided by the					
	Dietary Manag	ger on 04/14/2011 at					
	2:30 p.m. The	e policy indicated,					
	"Meat, fish,	and poultry are stored					
	on lower shelv	ves below fruits,					
	vegetables, jui	ces, and breads to					
	prevent contar	nination"					
	An undated po	olicy, titled,					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP 04/15/2	LETED
NAME OF I	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	3	
CREASY	SPRINGS HEALTH	H CAMPUS		CREASY LANE ETTE, IN47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	provided by the on 04/13/2011 policy indicated your hands and after any of the After hand continued equipment and surfaces Befor aw foods. Before the continued of the co	ore and after handling				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	NNC	00	COMPL	ETED
		155777	B. WING			04/15/2	011
			p. whie		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	L			CREASY LANE		
CREASY	SPRINGS HEALTH	H CAMPUS			TTE, IN47905		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
F0441 SS=D	Infection Control F a safe, sanitary ar and to help prever transmission of dis (a) Infection Contr						
	Program under wh (1) Investigates, confections in the fatorial confections in the fatorial confection	ontrols, and prevents					
	determines that a prevent the spread must isolate the re (2) The facility mu communicable dis lesions from direct their food, if direct disease. (3) The facility mu hands after each of	ction Control Program resident needs isolation to d of infection, the facility esident. st prohibit employees with a ease or infected skin t contact with residents or contact will transmit the st require staff to wash their direct resident contact for ng is indicated by accepted					
	transport linens so infection. Based on observe record review, th isolation standard residents with in	andle, store, process and of as to prevent the spread of ation, interview, and he facility failed to ensure ds were maintained for fectious diseases and appropriate handwashing	F04	41	CORRECTIVE ACTION1 - Resident #27 was admitted of her current stay on 3/30/11. / other assessments and care plans noted in the finding are relevant to the current stay a	All not	05/15/2011

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R2L311 Facility ID:

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	LDING	00	COMPL	ETED
		155777	B. WIN			04/15/2	011
		<u> </u>	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF I	PROVIDER OR SUPPLIE	R			CREASY LANE		
CREASY	SPRINGS HEALTI	H CAMPUS		1	ETTE, IN47905		
					- 112, 1147, 300		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	ŧ	R LSC IDENTIFYING INFORMATION)	+	TAG			DATE
		of scissors during a			resident #27 was not in isola		
	dressing change	. These deficient			on prior stays. The Clinical (Coordinator and Hospice nu		
	practices affecte	d 2 of 2 residents in			did meet with the resident's		
	isolation, and 1	of 2 residents observed			on 4-14-11 and educated the	•	
	during dressing	changes in a sample of 10			about isolation procedures a	and	
		ed for infection control.			personal protective		
	(Residents #18,				equipment. The nurse		
					observed leaving the reside	nt's	
	Eindings in sluds				room with a mask on was educated regarding proper		
	Findings include	.			isolation technique and to re	move	
					the mask and wash hands b		
		6:50 A.M., during an			leaving the resident's		
	initial tour with	LPN #3, Resident #27			room. Hospice resident #27	did	
	was identified as	s being in isolation for			expire on 4-22-11.2 - The th		
	"MRSA (methic	illin-resistant			staff member was instructed		
	staphylococcus a	aureus) in her sputum."			the proper precautions to tall when entering resident roon		
	There was a sign	n on the door which			residents with isolation	15 01	
	1	e see the nurse before			precautions in place. 3 -		
		d barrels sitting in the			Regarding infection control t	for	
	bathroom. The d				resident #21 during the dres	sing	
		ioor was open.			change, the nurse was		
	On 4/11/11 of 0:	25 A.M., Resident #27			immediately instructed on pu technique and acknowledge		
		*			error and acknowledged an	u nei	
	1	ing in bed in her room.			understanding of the proper		
		tor in the room. He did			technique for infection		
	not have a mask	on.			control. IDENTIFY OTHER		
					RESIDENTSIsolation proce		
	Interview on 4/1	1/11 at 11:15 A.M. with			were reviewed for all resider		
	CNA #6 indicate	ed the resident was in			isolation and proper procedule were in place.	ıres	
	"respiratory isola	ation" and staff should			MEASURES/SYSTEMIC		
	1 1	gown in the room.			CHANGESAll department st	affs	
					including therapy will be		
	Interview on 4/12/11 at 8:55 A.M. with				in-serviced on the policies a		
					procedures for isolation and		
		d "they had found			infection control including ha		
		r lungs. MRSA. The			washing. Licensed nurses w	/III be	
	Licolation is just f	for cafety precautions	1		in-serviced on the proper		i

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	(X3) DATE SURV	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETE	D
		155777	B. WING			04/15/2011	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				CREASY LANE		
CREASY	SPRINGS HEALTH	I CAMPUS			ETTE, IN47905		
							(1/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	E CC	OMPLETION DATE
IAU		<u> </u>	1	IAU	disinfecting of scissors during	,	DATE
	You just have to	wear a mask for			dressing changes. MONITOR		
	respiratory."				CORRECTIVE ACTIONDirect		
					of Health Services or designe	I .	
	On 4/12/11 at 9:1	10 A.M., LPN #1 was			will review any residents with		
	observed leaving	Resident #27's room.			isolation precautions to ensu		
	She had a mask i	n her hands and carried it			appropriate interventions are		
	down the hall and	d disposed of it in the			implemented; will observe a randomly selected nurse		
		he was not observed to			performing dressing changes	,	
	 wash her hands a	after leaving the room.			three times weekly for four		
		8			weeks to ensure correct		
	 Resident #27's cl	inical record was			technique (if residents in-hou		
		/11 at 10:10 A.M. The			require dressing changes) ar		
					then every other week for for		
		nitted with diagnoses			weeks and then monthly; and observe hand washing techn		
	· ·	but were not limited to,			in randomly selected	ique	
	cerebrovascular a				employees in each departme	nt	
	pneumonia, and	left parietal infarct.			two times weekly for four we	eks	
					and then one time weekly for		
	A hospital discha	rge summary dated			weeks and then monthly as p		
	3/30/11 indicated	l "recent			of the ongoing QA process. To QA committee will review aud		
	methicillin-resist	ant Staphylococcus			and observation reports and		
	aureus pneumoni	ia."			negative trends are noted the		
	1				committee will recommend		
	A Nursing Admis	ssion Assessment dated			changes in interventions. The	•	
		I the resident had			effectiveness of those	d at	
	short-term memo				interventions will be assesse the following monthly meetin		
		asesMRSA N (no			ensure the facility's policy an		
		•			procedure for isolation and		
]	e was no documentation			infection control is followed.		
		plan to address the					
		espiratory MRSA or					
	being in isolation	1.					
	A Minimum Data	a Set Admission					
	Assessment date	d 1/7/11 indicated the					
	resident was cog	nitively intact and was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
		155777	A. BUI B. WIN			04/15/2	011
	PROVIDER OR SUPPLIER SPRINGS HEALTH			1750 S	DDRESS, CITY, STATE, ZIP CODE CREASY LANE ETTE, IN47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
M		or quarantine for active		mo			DAIL
	3/31/11, 4/1/11, 4 indicated docume	lan dated 1/19/11, 4/5/11, 4/6/11, and 4/7/11 entation was lacking plan to address the and isolation.					
	indicated Met c (son'sthey discu precautions due t MRSAThey als concerned because	so respiratory so stated, 'no one seemed se they quit gowning up oves' referring to hospital					
	surveyor interver (continue) dropp	ler dated 4/13/11, after ntion, indicated "Cont let (sic) precautions. ulture if res (resident)					
	the Director of H indicated the clin monitors and pro She indicated fan regarding isolation	4/11 at 10:20 A.M. with fealth Services (DHS) nical care coordinator vides education to staff. milies should be educated on. She indicated the iratory MRSA and the ecautionary."					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777			ULTIPLE CO LDING IG	00		ESURVEY LETED 2011
NAME OF 1	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE	!	
CDEAGY	SPRINGS HEALT	LI CAMDIIS		1	CREASY LANE ETTE, IN47905		
					_		1 775
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL)		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
	2. On 4/11/11 at	6:50 A.M., during an					
	initial tour with	LPN #3, Resident #18					
	was identified as	s being in isolation for					
	C-Diff (clostridi	ium difficile [a bacteria]).					
	The door was or	pen. There was a sign on					
	the door indicati	ing "Please see the Nurse					
	-	"There were red barrels in					
	the bathroom.						
	On 4/12/11 + 14	0.15 A M DT #7					
		0:15 A.M. PT #7 was					
		ng in Resident #18's room. as leaning against the bed					
		resting on the footboard.					
	1	e gloves on. She did not					
		after she left the room.					
		rife was also in the room					
	and was not wea						
	and was not wee						
	Resident #18's c	elinical record was					
	reviewed on 4/1	4/11 at 8:35 A.M. The					
	resident was adr	mitted with diagnoses					
	which included,	but were not limited to,					
	C-Diff.						
	A 1						
		ry and physical dated d "recent Clostridium					
		and we will continue his					
	1	and we will continue his n (an antibiotic) here"					
	orar varicumych	i (an annoione) nere					
	A Minimum Da	ta Set Assessment dated					
	2/26/11 indicate	d the resident was					
	moderately impa	aired in cognitive skills,					
	required extensi	ve two-person physical					
	assist for transfe	er, required extensive					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155777	B. WIN			04/15/2	011
		<u> </u>	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R		1	CREASY LANE		
CREASY	SPRINGS HEALTI	H CAMPUS		1	ETTE, IN47905		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	` `	NCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE		DATE
		ical assist for toilet use					
		giene, and was not in					
	"isolation or qua	rantine for active					
	infectious diseas	se"					
	A Minimum Dat	a Set Assessment dated					
		d the resident was					
		aired in cognitive skills,					
	1 -	ve one-person physical					
	1 *	1 1 2					
	1	r and personal hygiene,					
	1 -	ve two-person physical					
	1	ise, and was not in					
	"isolation or qua	rantine for active					
	infectious diseas	se"					
	A resident care p	olan dated 2/2/11					
	1 ^	Diff infectionfollow					
		ion protocolsfollow					
	1 -	-					
	1	e precautionscontact					
	1 '	provide resident/family					
	education"						
	An "Infection As	ssessment and Review"					
	dated 3/16/11 in	dicated "contact					
	isolation"						
	A laboratory rep	ort dated 3/16/11					
	1	ff toxin PositiveC-Diff					
	antigen Positive.						
	l						
		2/11 at 10:35 A.M. with					
	CNA #8 indicated the resident was in						
	isolation for C-D	Diff and gloves should be					
	worn when enter	ring the room but no mask					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777		(X2) MULTIPLE C	ONSTRUCTION 00	CON	TE SURVEY MPLETED 5/2011	
	PROVIDER OR SUPPLIER		1750 S	ADDRESS, CITY, STATE, ZIP S CREASY LANE 'ETTE, IN47905	_	<i>5</i> .2011
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION
TAG	or gown.	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	RN #2 indicated contact with the gloves should be should wash their the room. Interview on 4/14 the DHS indicated educated related Interview on 4/14 the DHS indicated instructed staff restructed staff restructed staff restructed staff restructed hospically it was the facility educate the family Review on 4/12/ undated facility provided by the Intitled "Droplet Provided in the staff restricted in the staff restricted in the staff restricted staff restricted in the staff restricted in the staff restricted staff restricted in the	4/11 at 11:47 A.M. with ad the staff was verbally egarding isolation but umentation. She educated the family but by responsibility to				
	Review on 4/12/ undated facility p provided by the l "Contact Precaut latex gloves whe	naskupdate care plan" 11 at 11:28 A.M. of an policy and procedure Payroll clerk #9 and titled ions" indicated "Wear in entering the room ith the resident or				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777		(X2) MULTIF A. BUILDING B. WING		OO	(X3) DATE S COMPL 04/15/2 (ETED	
	PROVIDER OR SUPPLIER		ST1	'50 S C	DDRESS, CITY, STATE, ZIP CODE CREASY LANE TTE, IN47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	wash hands after resident, possible potentially conta objects and between interventionvisto properly gown given educational precautionsupd 3. The clinical # 21 was revied 10:05 a.m. Diagnoses including the penetomy, despenetomy, despenetomy, despenetomy, despenetomy, despenetomy in the penetomy in the penetom	order, dated					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777		A. BUILDING		NSTRUCTION 00	(X3) DATE: COMPL 04/15/2	ETED	
	PROVIDER OR SUPPLIER		175	50 S (DDRESS, CITY, STATE, ZIP CODE CREASY LANE TTE, IN47905	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR to fit - BID (tv	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) vo times daily)"	ID PREFI TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	treatment to R groin area on 0 a.m. The RN after removing then reached in retrieve a pentreatment with gloves or wash saline gauze st wound were contained at 10:30 a.m., Health Services should have chafter reaching indicated the state at 10:40 a.m., should have chafter reaching an integration of the state of the sta	rview on 04/12/2011 RN # 2 indicated she nanged her gloves into her pocket. She cissors should have					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
THEFTERN	or connection	155777	A. BUILDING		04/15/2011
			B. WINGSTREET.	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			CREASY LANE	
CREASY	SPRINGS HEALTH	I CAMPUS	LAFAY	ETTE, IN47905	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
F0514 SS=D	Guidelines for was provided to 04/14/2011 at 2 indicated, " V and water Pure disposable glosseissors, make with antiseptic soiled dressing 3.1-18(b). The facility must meach resident in accomplete; accurate accessible; and sy. The clinical record information to identhe resident's asseand services provipreadmission scresstate; and progress Based on record facility failed to evere complete armedication and dadministration. The effected 2 of 10 medicated accessible and accessible accessible and accessible and accessible accessible and accessible accessible and accessible accessible accessible and accessible acc	2:15 p.m. The policy Vash hands with soap t on second pair of vesIf using sure it is clean (SIC) after contact with ss" maintain clinical records on coordance with accepted ards and practices that are ely documented; readily stematically organized. must contain sufficient tify the resident; a record of essments; the plan of care ded; the results of any ening conducted by the	F0514	CORRECTIVE ACTION1A - physician for resident #13 wa contacted regarding clarificat on the Metoprolol parameters on 4-14-11 ordered "Metoproparameters - hold for systolic BP<110 and pulse <60". 1B supplement order for residen was evaluated and a require notation for percentage (%) of supplement consumed was	as stion s and solol s and solol s and solol s and solol s and s a

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE S			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155777	B. WIN			04/15/2	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			CREASY LANE		
CREASY	SPRINGS HEALTH	-I CAMPUS			ETTE, IN47905		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	•	TAG			DATE
	Findings include	:			added to the Medication Administration Record. This		
					resident discharged home or	,	
	1 A. Resident #1	3's record was reviewed			4-25-11.2A, 2B and 2C - An	'	
	on 4/11/11 at 10:	:40 a.m. Diagnoses for			investigation was initiated		
	Resident #13 inc	eluded, but were not			regarding the medications no	ot	
		tes mellitus, dementia,			documented as administered		
	·	failure, chronic atrial			The medications were given		
	"				the resident but documentati	on of	
		ertension, CVA (stroke),			administration had not been		
		l vascular disease,			properly completed. Education and counseling was provided		
	_	e left great toe, and			the nurses not properly	101	
	peripheral neuro	pathy. The record			documenting medication		
	indicated the res	ident had multiple			administration. IDENTIFY		
	diabetic ulcers of	n his feet.			OTHER RESIDENTSAII heal	lth	
					center residents with suppler		
	Medication adm	inistration records (MAR)			orders were evaluated and a		
		ough 4/11/11 indicated the			required notation for percent		
		d "metoprolol (blood			(%) of supplement consumed was added to each resident's		
		• `			Medication Administration	•	
	1 ^	tion) 50 mg (milligrams)			Record. All current		
	1 -	mouth twice a day for			residents' Medication		
		ion)" Hand written on			Administration Records have	:	
	the MAR was a	statement that indicated			been reviewed and if		
	"hold SBP (sys	stolic blood pressure) >			documentation of medication		
	(greater than) 11	0: HR (heart rate) >			administration was found lac investigation, education and	king,	
	60" Documer	ntation related to hold			counseling is being provided	for	
	parameters was i	incorrect.			the affected nurses.		
	T				MEASURES/SYSTEM		
	During an interv	iew with LPN #4 on			CHANGESLicensed nursing		
	1	a.m., she indicated the			will be in-serviced to docume	ent	
					the percentage (%)	all	
	_	on the medication were			of supplement consumed for supplement orders for reside		
	incorrect. She in				MONITORING CORRECTIV		
	1 ^	ld have been hold for SBP			ACTIONDirector of Health	_	
	< 110 and heart i	rate < 60.			Services or designee will rev	iew	
					all physician orders at the Cl	inical	
	During an interv	iew with the Clinical			Meeting Monday through Frid	day	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155777	B. WIN	IG		04/15/2	011
NAME OF I	PROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	CREASY LANE		
CREASY	SPRINGS HEALTI	H CAMPUS		LAFAYE	ETTE, IN47905		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	.	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		r #11 on 4/13/11 at 10:35			and will ensure that orders for supplements have been		
		ed the hold parameters for			properly entered on the		
	the metoprolol w	vere incorrect.			Medication Administration Re	ecord	
					including a space for the		
	During an interv	iew with the Director of			percentage (%) of suppleme		
	Health Services	(DHS) on 4/13/11 at 3:30			consumed to be recorded. To Medication Administration	ne	
	p.m., she indicat	ed the hold parameters			Records will be reviewed thr	ee	
	for the metoprole	ol were incorrect as you			times weekly for four weeks		
	would hold the r	nedication if the SBP was			ensure the documentation of		
	less than 110 or	the heart rate was less			administration and percentag		
	than 60. She ind	licated the facility was			(%) of supplements are reco then every other week for for		
	unable to find a	physicians order to			weeks, then monthly as part		
	identify where th	ne hold parameters came			the ongoing QA process. The	e QA	
	from.				committee will review audit		
					reports and if negative trends noted the QA committee will	s are	
	1 B. The clinica	l record indicated			recommend changes in		
	Resident #13 wa	s admitted to the facility			interventions. The effectiven	ess	
	with numerous d	liabetic ulcers to his feet.			of those interventions will be		
	To aide in healin	g of the diabetic ulcers			assessed at the following mo		
	the resident rece	ived a dietary			meeting to ensure the facility policy and procedure for	5	
	supplement.				documentation of supplemen	nts	
					and medication administration	n are	
	MAR dated 4/1/	11 through 4/11/11			followed.		
	indicated the res	ident received "Juven- 1					
	packet 2 X/ day.	" Documentation was					
	lacking to indica	te the amount of the					
	supplement the r	resident consumed.					
	During an interv	iew with LPN #4 on					
	1	a.m., she indicated the					
		the resident drank should					
	have been docum	nented on the MAR.					
	During an interv	iew with the Clinical					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155777		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/15/2 (ETED	
NAME OF I	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP CODE CREASY LANE		
CREASY	SPRINGS HEALTH	1 CAMPUS		LAFAYE	ETTE, IN47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	a.m., she indicate the resident considerate documented on the facility woulknowing whether	r #11 on 4/13/11 at 10:35 ed the amount of Juven umed should have been he MAR. She indicated d have no way of r the intervention was a knowing how much the ed.					
	Health Services p.m., she indicat	iew with the Director of (DHS) on 4/13/11 at 3:30 ed the amount of Juven umed should have been he MAR.					
	on 4/14/11 at 11: included, but we	lisease, hypertension,					
	indicated the res "Metolazone (l medication) 2.5 orally every other Documentation with the resident rece						
	indicated the res	1 4/1/11 through 4/11/11 ident received 1 10 MEQ (millimeters					

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'		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED			
		155777	A. BUII B. WIN			04/15/2011			
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE				
				1750 S CREASY LANE					
CREASY	SPRINGS HEALTH	1 CAMPUS	LAFAYETTE, IN47905						
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE		
1710	equivalent)cap (capsules) give 2			1710			DATE		
	capsules (20 MEQ) by mouth twice a day with meals for supplement"								
	Documentation was lacking to indicate								
	the resident received the medication as ordered at bedtime on 4/9, 4/10, and								
	4/11/11.								
	3 B. MAR dated 4/1/11 through 4/11/11								
	indicated the resident received "Lipitor								
	(lipid reducing medication) 40 mg give 1								
	tablet by mouth every bedtime for								
	hyperlipidemia" Documentation was								
	lacking to indicate the resident received the medication as ordered at bedtime on								
	4/10 and 4/11/11.								
	During an interview with the Clinical								
	Care Coordinator #11 on 4/13/11 at 10:35 a.m., she indicated there should be no								
	holes in documentation on the MAR's. During an interview with the Clinical								
	Care Coordinator #10 on 4/14/11 at 2:00								
	p.m., she indicated the medications had								
	been given by the nursing staff but had								
		off on the MAR. She							
		nould be no holes in the							
	MAR's.								
	A policy and pro	cedure dated 2/1/10,							
		n Administration-General							
Guidelines" provided by the Executive Director on 4/14/11 at 1:55 p.m.,									

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	A. BUILDING B. WING	00	COMP: 04/15/2	LETED		
NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LANE LAFAYETTE, IN47905					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE		
	individual who a medication dose administration or directly after the the end of each in person administer reviews the MAI doses were administered the off-duty without							